UNITED STATES DISTRICT COURT
SOUTHERN DISTRICT OF NEW YORK

----------X

ANONYMOUS OXFORD HEALTH PLAN MEMBER WITH ID #6023604*01, on behalf of himself and all others similarly situated,

Plaintiff,

-against-

OXFORD HEALTH PLANS (NY), INC., a New York Corporation, UNITED HEALTHCARE SERVICES, INC., a Minnesota Corporation, and UNITED HEALTHCARE, INC., a Delaware Corporation,

Defendants.

----------X

Civ. Act. No. 08 CV 00943 (PAC)

DECLARATION OF RODNEY LIPPOLD

DOCUMENT
ELECTRONICALLY FILED

RODNEY LIPPOLD, pursuant to 28 U.S.C. §1746(2) declares the following:

1. I am an employee of United HealthCare Services, Inc. as the Director of Enrollment. As part of my duties, I am responsible for group enrollment, including renewal of group enrollment agreements, and member enrollment for employer groups of 1-99 employees in size for United HealthCare, Inc. affiliates, including the defendants Oxford Health Plans (NY), Inc. ("Oxford"), United Healthcare Services, Inc. and United Healthcare, Inc. As Director of Enrollment, I review the records related to group enrollment regularly created and maintained by defendants in the regular course and scope of their business. As such, I am personally familiar with the pertinent facts raised by plaintiff's motion based on my experience in this position and my review of defendants' records.

2. My investigation into the issues raised by plaintiff in his class action complaint reveals the following:

(A) Entwistle & Cappucci, LLP (the "Group") submitted an New York Community Rated Group Application to Oxford dated August 10, 1998. A true and correct copy of the Application is annexed hereto as Exhibit "A."

(B) The Group and Oxford entered into a Group Enrollment Agreement effective September 1, 1998, which was renewed and effective September 1, 2000 through September 1, 2003 ("2000 GEA"). A true and correct copy of the 2000 GEA is annexed hereto as Exhibit "B."

(C) On or about July 17, 2002, plaintiff submitted an individual application on-line for enrollment in the Group plan. A true and correct copy of the printout of the on-line application is annexed hereto as Exhibit "C."

(D) Oxford issued to plaintiff a Certificate of Coverage (the "2002 Certificate") in accord with the 2000 GEA effective September 1, 2002 to September 1, 2003. A true and correct copy of the 2002 Certificate is annexed hereto as Exhibit "D."

(E) The Group and Oxford entered into a new Group Enrollment Agreement effective September 1, 2003 (the "2003 GEA"). A true and correct copy of the 2003 GEA is annexed hereto as Exhibit "E."

(F) Oxford issued to plaintiff a Certificate of Coverage (the "2003 Certificate") in accord with the 2003 GEA effective September 1, 2003 to September 1, 2004. A true and correct copy of the 2003 Certificate is annexed hereto as Exhibit "F."

(G) Oxford issued to plaintiff a Certificate of Coverage (the "2004 Certificate") in accord with the 2003 GEA effective September 1, 2004 to September 1, 2005. A true and correct copy of the 2004 Certificate is annexed hereto as Exhibit "G."

(H) Oxford issued to plaintiff a Certificate of Coverage (the "2005 Certificate") in accord with the 2003 GEA effective September 1, 2005 to February 1, 2006. A true and correct copy of the 2005 Certificate is annexed hereto as Exhibit "H."

(I) In or around January 17, 2006, the Group applied for large group health insurance coverage effective February 1, 2006. A true and correct copy of the Large Group Enrollment Form is annexed hereto as Exhibit "I."

(J) The Group and Oxford entered into the Oxford Group Enrollment Agreement (the "2006 GEA") effective February 1, 2006. A true and correct copy of the 2006 GEA is annexed hereto as Exhibit "J."

(K) Plaintiff submitted an individual application form dated January 10, 2006 for his enrollment in the Group Plan. A true and correct copy of the individual application is annexed hereto as Exhibit "K."

(L) Oxford issued to plaintiff a Certificate of Coverage (the "2006 Certificate") in accord with the 2006 GEA effective February 1, 2006 to February 1, 2007. A true and correct copy of the 2006 Certificate is annexed hereto as Exhibit "L."

(M) Oxford issued to plaintiff a Certificate of Coverage (the "2007 Certificate") in accord with the 2006 GEA effective February 1, 2007 to February 1, 2008. A true and correct copy of the 2007 Certificate is annexed hereto as Exhibit "M."

Dated: Hooksett, New Hampshire
April 14, 2008

I declare under penalty of perjury that the foregoing is true and correct.

RODNEY LIPPOLD

CERTIFICATE OF SERVICE

I, MICHAEL H. BERNSTEIN, hereby certify and affirm that a true and correct copy of the attached **DECLARATION OF RODNEY LIPPOLD** was served via ECF and Regular Mail on this 14th day of April, 2008, upon the following:

Eric B. Fisher Esq.
Morgenstern, Fisher & Blue, LLC
885 Third Avenue
New York, New York 10022

s/
MICHAEL H. BERNSTEIN (MB-0579)

Dated: New York, New York
April 14, 2008

EXHIBIT A

8037701869

Oxford Health Plans

New York Community Rated Group Application

Oxford Health Plans (NY), Inc. • Oxford Health Insurance Inc.

Mailing Address: P.O. Box 7081, Bridgeport, CT 06601-7081 **Corporate Address:** 800 Connecticut Ave., Norwalk, CT 06854 • 203-852-1442 • 800-444-6222

Oxford. *The Health & Healing Company.*™

I. GENERAL INFORMATION

☐ **Existing Group** ☑ **New Group** EC1227

1. **Full legal name of firm:** Entwistle & Cappucci LLP
2. **Address of firm;** (Street Address, City, State, Zip Code) 330 Madison Ave New York NY 10017
3. **Plan Administrator/Contact:**
   a. Name and Title: ANDREW ENTWISTLE
   b. Address: (If it differs from address of firm; cannot be a P.O. Box)
   c. Phone Number: 212 867 1030
4. **Name and title of person to receive billing statements:** SAME AS ABOVE
   a. Name
   b. Title
   c. Address: (If it differs from address of firm; cannot be a P.O. Box)
   d. Phone Number:
   e. Fax Number: 212 697 8747
5. **Full legal name of each subsidiary and/or affiliated company whose employees are to be covered:**
6. **Nature of business:** LAW FIRM
7. **SIC Code:** 8111
8. **Tax identification number:** 13- REDACTED

8037701870

Oxford Health Plans
Oxford Health Plans (NY), Inc.
Oxford Health Insurance, Inc.
800 Connecticut Ave., Norwalk, CT 06854

8037701871

IV. RATE INFORMATION

A. Medical

Group location and number of Members in each location:

- ☐ Bronx ____ ☐ Rockland ____ ☐ Suffolk ____
- ☐ Brooklyn ____ ☐ Putnam ____
- ☒ Manhattan ~~871~~ ☐ Orange ____
- ☐ Queens ____ ☐ Staten Island ____
- ☐ Westchester ____ ☐ Nassau ____

per fap.

Monthly Rates:

	Single	EE/Spouse	EE/Child	EE/Children	Family
$		~~297.13~~			~~764.39~~
IN	290.00	~~440.90~~			770.89
OUT					

B. Dental Freedom Plan (if applicable)

Group location and number of Members in each location:

- ☐ Bronx ____ ☐ Rockland ____ ☐ Suffolk ____
- ☐ Brooklyn ____ ☐ Putnam ____
- ☐ Manhattan ____ ☐ Orange ____
- ☐ Queens ____ ☐ Staten Island ____
- ☐ Westchester ____ ☐ Nassau ____

Monthly Rates:

	Single	EE/Spouse	EE/Child	EE/Children	Family
$					
IN					
OUT					

V. BASIC LIFE INSURANCE

(ADMINISTERED BUT NOT UNDERWRITTEN BY OXFORD)

Will Life Insurance be offered? ☐ Yes ☐ No (Life Insurance applies to active employees only)

Choose the policy amount: ☐ $15,000 flat ☐ $20,000 flat ☐ $25,000 flat

Is the Life Insurance Benefit contributory? ☐ Yes ☐ No Number of Eligible Employees: _____

Rates: Basic Life: $ _____ per thousand AD&D: $ _____ per thousand (same schedule as Life)

VI. BROKER/AGENT INFORMATION

	BROKER	AGENT
1. Full legal name of firm:	Stanwich Incorporated	Arnold S. Bernstein
2. Address of firm:	3 Manhattanville Road Purchase N.Y. 10577	
3. Contact:	Arnold Bernstein	
4. Telephone/Fax Number:	914-253-0701	
5. Social Security # or Fed. Tax ID #:	13- REDACTED	
6. Broker ID Code:	BC0474	

VII. APPLICANT AGREEMENT

This application and the premium rates proposed by Oxford are **subject to Home Office approval in writing by Oxford** and may change due to differences in selection of benefits as determined by Oxford. The Applicant hereby acknowledges that **this application does not constitute any obligation by Oxford to offer coverage to the Applicant until such application is accepted in writing by the Home Office of Oxford.** The Applicant hereby confirms that it will not cancel any health coverage it may currently have in anticipation that this Application will be accepted by Oxford and that **Oxford shall have no obligation to provide coverage to Applicant unless this Application is formally accepted in writing by the Oxford Home Office.** Further, I hereby certify on behalf of the Applicant that the Applicant has not had group health coverage terminated within the past 12 months due to failure to pay premiums.

Dated at: New York City this 10th day of August 1998.

Entwistle & Cappucci LLP
(Full Legal Company Name)

The above named company confirms that we employ no more than 50 full-time non-union employees and no fewer than 2 full-time non-union employees. I understand that 1099-compensated individuals are not eligible for group coverage with Oxford Health Plans.

Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime, and shall also be subject to a civil penalty not to exceed $5,000 dollars and the stated value of the claim for each violation.

Oxford Health Plans(NY), Inc.

X _____ (PARTNER)
Signature of Authorized Officer of the Company — Title

_____ _____ for Steven Jacobs
Witness — Duly Licensed Resident Agent/Broker

Oxford Health Insurance, Inc.

X _____ (PARTNER)
Signature of Authorized Officer of the Company — Title

_____ _____ for Steven Jacobs
Witness — Duly Licensed Resident Agent/Broker

Note: Please make check payable to Oxford Health Plans.

II. ADMINISTRATIVE INFORMATION

The term "coverage" means the benefits provided by Oxford, pursuant to the Group Certificate(s).

1. **Effective date:** We request that this coverage be effective: 9/1/98 (Month/Day/Year).
2. **Anniversary date:** The anniversary date is the first day of the calendar month which is closest to the effective date.
3. **Open enrollment period:** 8 (Month). OPEN ENROLLMENT PERIOD WILL BE THE MONTH PRIOR TO YOUR RENEWAL DATE, UNLESS OTHERWISE SPECIFIED.

4a. **Other group health or HMO coverage:** Indicate below other group health or HMO coverage, including Oxford Health Plans, which is still in force or which terminated within the past three years.

Type of coverage	Name of carrier	Effective date	If terminated, date terminated
MED	OXFORD	9/94	8/31/98

4b. **Credit Prior Carrier Deductibles?** ☑ Yes ☐ No

Prior Carrier Deductible information: Single: $ 250 Family: $ 625

5. **Employee Eligibility:** All permanent, full-time employees who work at least 30 hours per week (minimum 20 hours/week).

Are any classes excluded? ☐ Yes ☑ No If yes, indicate classes excluded: _____

CLASS I

Definition of Class I _____

a) **Waiting period** 30 **days/months from date of hire.**

i) **Eligibility**

☑ On the date the employee completes the waiting period.

Termination

Date of termination of employment.

ii) **Eligibility**

☐ First of the month after the employee completes the waiting period.

Termination

On the last day of the calendar month in which employee's employment terminates.

b) **Should the eligibility lag be waived for rehire?**

☑ Yes ☐ No

(if rehired within _____ months).

c) **Eligibility lag for present employees?**

☐ No ☑ Same as new hires (Standard)

CLASS II

Definition of Class II _____

a) **Waiting period** _____ **days/months from date of hire.**

i) **Eligibility**

☐ On the date the employee completes the waiting period.

Termination

Date of termination of employment.

ii) **Eligibility**

☐ First of the month after the employee completes the waiting period.

Termination

On the last day of the calendar month in which employee's employment terminates.

b) **Should the eligibility lag be waived for rehire?**

☐ Yes ☐ No

(if rehired within _____ months).

c) **Eligibility lag for present employees?**

☐ No ☐ Same as new hires (Standard)

Eligibility & Termination: the employee will become eligible on the latter of the effective date of this plan or the date selected above (check appropriate date).

6. **Number of Employees Eligible on Effective Date:** Active Employees 87 Retired Employees _____

How many employees will enroll with Oxford Health Plans? 7-9

8037701874

7. **Continuation of Coverage:** Are there any former employees who have been paying you for coverage since they stopped working for you? 8037701875
(Either COBRA or State Continuation Provisions) ☐ Yes ☑ No

If yes, please specify who those individuals are:

Name Qualifying Event and Date

_____

_____

_____

III. PRODUCT/PLAN DESIGN

1. **Product:** ☑ Freedom Plan ☐ Freedom Plan Select ☐ Liberty Plan* ☐ Liberty Plan Select

2.

COPAY \ DEDUCTIBLE	$200	$250	$300	$500	$750	$1,000
$5						
$10		✓				
$15						
$20						

*Liberty Plan is not available with a $5, $10, or $15 copay with a $200 or $250 deductible plan. It is also not available on a $15 copay with a $10,000 coinsurance limit.

3. **Coinsurance %:** ☐ 70% ☑ 80%

4. **Coinsurance Limit:** ☑ $5,000 ☐ $10,000

5. **UCR Level:** ☐ Standard ☐ High ☑ Very High

6. **Pharmacy Benefit:**

a. MAC A ☐ Yes ☐ No

b. MAC C ☐ Yes ☐ No

c. Generic/Brand co-pay ☐ Yes ☐ No ☐ $2/$5 ☑ $5/$10 ☐ $5/$15* ☐ $7/$20

d. Deductible ☑ $50 ☐ $75 ☐ $100

e. Contraceptives ☐ Yes ☐ No

f. Annual Cap ($3000) ☐ Yes ☐ No

Deductible option is not available with this copay combination

7. **Dental Freedom Plan:**

Within each class one box must be chosen for in-network and out-of-network coverage.

	In-Network	Out-Of-Network
CLASS I (Preventive)	☐ 100%	☐ 80% ☐ 70% ☐ 60% ☐ 50%
CLASS II (Basic Restorative)	☐ 100% ☐ 90% ☐ 80%	☐ 80% ☐ 70% ☐ 60% ☐ 50%
CLASS III (Major Restorative)	☐ 80% ☐ 70% ☐ 60% ☐ 50%	☐ 50% ☐ 40% ☐ 30%

Note: Minimum of 20% difference between in-and out-of-network coinsurance options is required.

Please check the appropriate deductible and annual benefit maximum amount.

Annual Deductible Per Person* (No In-Network Deductible)

☐ $50
☐ $100
☐ $150

* Applies to Class II & III services.

Annual Benefit Maximum Per Person (In-/Out-of-Network)

☐ $1,000 / $500
☐ $1,500 / $750
☐ $2,000 / $1,000
☐ $3,000 / $1,500

8. **Other Riders:**

☐ Dental Premium ☐ Dental Enhanced
☐ $250 Hospital Deductible ☐ $500 Hospital Deductible
☐ Vision ☐ Skilled Nursing
☑ Mental Health ☐ Alternative Medicine _____
☐ Enhanced Chiropractic Services ($1000) ☐ Other _____

Dependent Student Cutoff: ☐ Standard Age 23 ☐ Adjusted Age 25

EXHIBIT B

OXFORD HEALTH PLANS (NY), INC.
OXFORD GROUP ENROLLMENT AGREEMENT

Group Name: **Entwistle & Cappucci L.L.P. ('Group')**

Group Number: **EC1227*CSP01** Effective Date: **September 1, 2000**

DEFINITIONS:

- Agreement: This Group Enrollment Agreement, the Group Application, the individual applications of the Members, the Certificate of Coverage and Member Handbook, the Summary of Benefits and any applicable Riders.
- OHPNY, Us, We, Our: Oxford Health Plans (NY), Inc.
- Members: Subscribers and Covered Dependents
- Terms not defined in this Group Enrollment Agreement will have the meaning set forth in the Certificate.

In consideration of the payment of Premiums, OHPNY and Group agree that OHPNY will arrange or pay for Covered medical and hospital services in accordance with the terms and provisions of the Agreement. Such services will be provided for the Group's eligible employees (Subscribers) and their Covered Dependents.

I. EFFECTIVE DATE AND TERMS OF AGREEMENT:

The Agreement will be effective on the 1st day of September, 2000 at 12:00 a.m. Eastern Time and will remain in effect for a period of 12 consecutive months, ending on the 31st day of August, 2001 at 11:59 p.m. Eastern Time at which time coverage provided under this Agreement will terminate (the 'Initial Contract Period'). The Agreement, and the coverage provided under the Agreement, will automatically renew after the end of the Initial Contract Period or any Subsequent Contract Period unless it would otherwise terminate in accordance with Section XIII of this Group Enrollment Agreement.

II. COVERAGE:

Benefit Plan Code/Description: Freedom Plan - Very High Option UCR - $10 Copay

80% of $5,000 after $250 deductible

Optional Benefit Riders:

Prescription Drugs
$5 copay per generic prescription
$15 copay per preferred brand prescription
$50 copay per brand name prescription
(includes oral contraceptives)

Mental Health: See Attached Summary

III. PREMIUM RATE SCHEDULE:

Type of Coverage	Total Monthly Premium
Single	$347.90
Employee/Spouse	$675.64
Parent/Children	$686.07
Family	$1,078.51

IV. ELIGIBILITY:

Eligible employees of the Group will be full-time employees of the Group who work a minimum of 30 (no less than 20) hours per week. In addition, eligible employees of the Group and their eligible family members will meet the eligibility criteria set forth in the Certificate and the requirements set forth below:

Subscribers: Subscribers will be eligible on the date occurring 30 days(s) after commencement of employment. Coverage ends on a date consistent with the eligibility start date selected above. (If subscribers are eligible the date the defined waiting period is complete, coverage will end on the termination date. If subscribers are eligible on the first of the month after the date the defined waiting period is complete, coverage will end on the last day of the month in which eligibility ends).

Such waiting period is waived for employees hired within 12 months after an approved leave of absence.

Covered Dependents: The legal spouse of the Subscriber and any unmarried, dependent children, as defined in the Certificate, are eligible for coverage. Such children are eligible only until the child reaches age 19 or age 23 if the child is a full-time student. Coverage ends on the last day of the Semester in which the child's birthday occurs.

The eligibility requirements in this section of this Group Enrollment Agreement are material to Our administration of the Agreement. During the term of the Agreement, We will not permit any change in these eligibility requirements unless We agree, in writing, to such change.

V. NOTICE:

All notices to be given to the Group will be addressed to:

Entwistle & Cappucci L.L.P.
Attn: Andrew Entwistle
400 Park Ave.
New York, NY 10022

Any notice hereunder to be given to Us will be addressed to:

Oxford Health Plans (NY), Inc.
10 Tara Boulevard
Nashua, NH 03062

VI. PREMIUM DUE DATE AND PAYMENTS

The first day of the month is the "Premium Due Date". The Group agrees to remit to Us on or before the Premium Due Date the applicable Total Monthly Premium set forth in Section III above for each Member enrolled as of such date. Membership as of such date will be determined by Us in accordance with Our Member records. If a Premium payment is not made in full by Group on or prior to the Premium Due Date, a 30-day Grace Period will be granted to the Group for payment without interest charge. If payment is not received by the expiration of the Grace Period, then the Agreement may be terminated by Us pursuant to Section XIII of this document. Premiums outstanding subsequent to the end of the Grace Period will be subject to a late penalty charge of 1.50% of the total Premium amount due. This amount will be calculated for each 30-day period, or portion thereof, that the amount due remains outstanding. If the Agreement is terminated for any reason, the Group will continue to be held liable for all Premium payments due and unpaid before the termination, incluing but not limited to, Premium payments for any time the Agreement is in force during the Grace Period.

Notwithstanding any language to the contrary in this Agreement,We will have no obligation to provide benefits or pay claims for any Member during any period for which the required Premium payment has not been made, including during any Grace Period. If We provide benefits or pay claims for any Member during any period for which the Premium payment has not been made, such provision of benefits or payment of claims will not constitute a waiver of Our right to discontinue the provision of coverage or payment of claims until such time as the Premium payment is made.

VII. PREMIUM ADJUSTMENTS:

A. Enrollment. If a Member enrolls on or before the fifteenth (15th) day of the month, the Group will remit to Us on or before the next Premium Due Date an additional Total Monthly Premium for such Member for the month in which the Member enrolled. If a Member enrolls after the fifteenth (15th) day of a month, no additional Premium payment will be due for such Member for the month in which the member enrolled. Note: This does not apply to any Group where the Subscribers become eligible for coverage on the first day of the month per Section IV, "Eligibility".

B. Termination. If a Member's coverage ends on or before the fifteenth (15th) day of a month, We will credit the Group the total Monthly Premium for such Member for that month. If a Member's coverage ends after the fifteenth (15th) day of a month, the Group will not be entitled to any Premium adjustment from Us. Note: This does not apply to any Group whose Subscribers lose coverage on the last day of the month, per Section IV, "Eligibility".

VIII. PREMIUM RATE CHANGES:

Initial Contract Period: The Premium Rate Schedule set forth on page one of this Group Enrollment Agreement will be valid only for the Initial Contract Period. Premium Rates for the Initial Contract period will not be changed by Us unless a change required by statute or regulation increases Our cost risk under the Agreement. If such a statutory or regulatory change occurs, We may change the Premium Rate Schedule at any time with a 45-day prior written notice to the Group.

Subsequent Contract Period: At any time, with a 45-day prior written notice, We may change the Premium Rate Schedule for any Subsequent Contract Period as follows:

- Upon the renewal of the Agreement; and
- When a change required by statute or regulation that increases Our risk under the Agreement

We may also change the Premium Rate for any other reason upon a 90-day prior written notice to the Group.

Regarding Renewals: If We fail to give the Group the required advance notice, the Premium Rates in effect prior to the commencement of the Subsequent Contract Period will remain in effect for a period of 45 days after the Group was notified by Us of the new Premium Rates for the Subsequent Contract period, after which period the new Premium Rates will go into effect.

Any change in the Premium Rates will be subject to the approval of the New York Insurance Department.

IX. MEMBER EFFECTIVE DATES OF COVERAGE:

Coverage of prospective Members will be subject to Our receipt of an Enrollment Form and applicable monthly Premium for each prospective Member within 31 days of the Member becoming eligible for coverage under the Agreement.

X. INELIGIBLE MEMBERS:

If the Group fails to immediately notify Us of a Member's ineligibility, and the Group has made or continues to make Premium payments for such Member, We will credit such Premium payment back to the last day of the month immediately prior to the month in which such termination notice is received by Us. We will provide this credit only if We have not authorized or incurred claims for health services for such Member during the period when We were unaware of the Member's ineligibility.

XI. OPEN ENROLLMENT PERIOD:

The Group will hold a Group Open Enrollment Period at least once each year. During the Group Open Enrollment Period, eligible employees, as determined by the Agreement, may elect coverage under the Agreement.

XII. RESPONSIBILITIES OF GROUP:

Group agrees to:

A. Offer coverage to eligible employees and their eligible family members, as described in Section IV above. It is agreed that eligible employees of the Group will be free to choose Our coverage or any other coverage as may be available through the Group during the initial and subsequent Group Open Enrollment Periods. Every eligible employee of the Group will be given fair opportunity to elect one of the Group's coverage options and will not be penalized by the Group because of his or her choice.

B. Offer each new employee the opportunity to elect Our coverage as a procedure of employment when he or she becomes an eligible employee as described in the Agreement.

C. Provide notification to each Member, within 15 days after termination of the Member's coverage, of the Member's right to convert to one of Our individual direct payment contracts, contingent upon the Member having reasonable access to Our Service Area.

D. Furnish to Us, on a monthly basis (or as otherwise required), on Our approved forms, such information as may reasonably be required by Us for the administration of the Agreement, including any change in a Member's eligibility status. In addition, We may, at reasonable times, examine the Group's pertinent records with respect to eligibility and Premium payments hereunder.

E. Comply with all policies and procedures established by Us in administering and interpreting the Agreement.

XIII. TERMINATION:

A. The Agreement may be terminated by Us:

i. Upon written notice, if any Premium payment or contribution required to be made by the Group is not received by the Premium Due Date, subject to a 30-day Grace Period;

ii. Upon written notice, if the Group ceases to operate or relocates outside of the Service Area;

iii. If the Group has performed an act or practice that constitutes fraud or made an intentional misrepresentation of material fact under the terms of the Agreement;

iv. We cease offering group contracts in New York in accordance with applicable law;

v. The Group ceases to meet the requirements for a group as defined under applicable law;

vi. In connection with this Plan, there is no longer any employee or dependent who lives, resides or works in the Service Area; or

vii. For such other reasons as are acceptable to the Superintendent of Insurance and not inconsistent with Public Law 104-191.

B. This Agreement may be terminated by the Group:

i. Upon written notice, in the event of the insolvency or bankruptcy of OHPNY;

ii Upon written notice, in the event of the revocation of OHPNY's Certificate of Authority;

iii. In the event of Our material breach of any of the terms and provisions of the Agreement, upon a 45-day prior written notice to Us;

iv. As of the date any Premium change would become effective, by providing Us with written notice of termination not less than 30 days prior to such effective date; or

v. Without cause, by giving Us a 30-day advance written notice.

XIV. ENTIRE AGREEMENT:

The Agreement constitutes the entire Agreement between the parties and supersedes all prior and contemporaneous arrangements, understandings, negotiations and discussions of the parties with respect to the subject matter hereof, whether written or oral; and there are no warrantees, representations, or other agreements between the parties in connection with the subject matter hereof, except as specifically set forth herein. No supplement, modification or waiver of the Agreement will be binding unless executed in writing by authorized representatives of the parties.

XV. APPLICABLE LAW:

This Agreement will be governed by the laws of the State of New York.

XVI. INCONSISTENCY:

In the event of any inconsistency between this Group Enrollment Agreement and the Certificate, the terms of this Group Enrollment Agreement will govern.

XVII. AMENDMENTS:

Any amendments to the Agreement must be in writing and must be approved by authorized representatives of both the Group and OHPNY. No other individual has the authority to modify the Agreement, waive any of its provisions or restrictions, extend the time for making a payment, or bind OHPNY by making any other commitment or representation.

Formal acceptance of an amendment to the Agreement by the Group will not be required if: the change has been negotiated by means of a request by the Group and agreed to by Us and such amendment is attached to this Group Enrollment Agreeement; if the change is required to bring the Agreement into conformance with any applicable law, regulation or ruling of the jurisdiction in which the Agreement is delivered or of the federal government; or if the Group makes payment of any applicable Premium on and after the effective date of such amendment.

OXFORD HEALTH PLANS, (NY) INC.	**Entwistle & Cappucci L.L.P. (GROUP)**
By:_____ *Authorized Signature*	**By:**_____ *Authorized Signature*
Title:_____	**Title:**_____
Date:_____	**Date:**_____

EXHIBIT C

DCN View

DCN 2195L03714 Submit

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Exhibit D

Pursuant to Rule 5 of the United States District Court for the Southern District of New York Procedures For Electronic Case Filing only excerpts of the referenced document have been electronically filed due to the volume of the exhibit.

(This exhibit has been Bates Stamped and a complete copy is being served on plaintiff.).

This filing is without prejudice to any parties' right to supplement the exhibit or file the complete document.

9/1/02

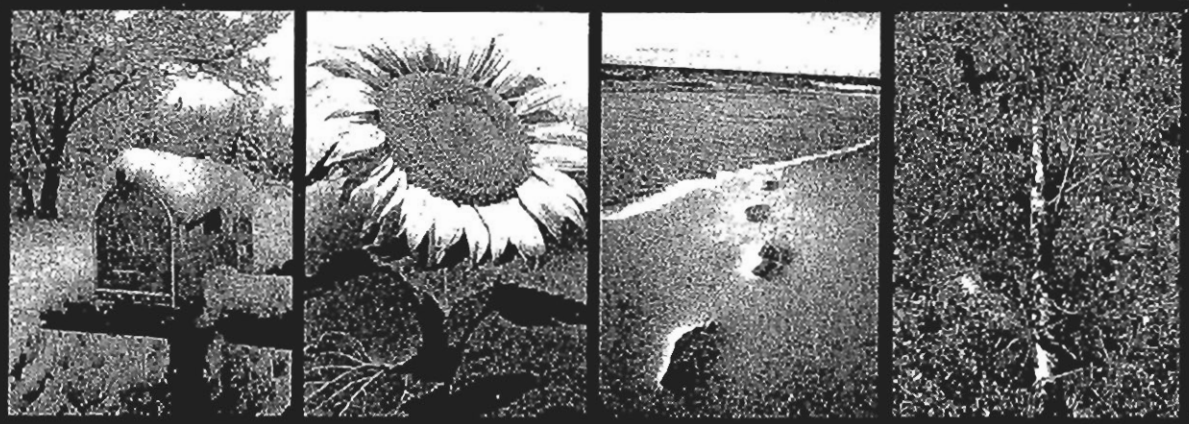
REDACTED

EC1227_CSP01

1050 FIFTH AVENUE

NEW YORK, NY 10028

Your Oxford Coverage
for all occasions



OXFORD HEALTH PLANS®

A UnitedHealthcare Company

REDACTED

EC1227_CSP01

1050 FIFTH AVENUE

NEW YORK, NY 10028

FREEDOM PLAN®

OXFORD HEALTH PLANS®

A UnitedHealthcare Company

20Feb2008
2184 (07/05)

OXFORD HEALTH INSURANCE (NY), INC.

Small Group Freedom Plan

SUMMARY OF BENEFITS

Entwistle & Cappucci L.L.P.

COVERED SERVICES	IN-NETWORK *	OUT-OF-NETWORK **
Primary and Preventive Care		
Physician Office and Home Visits	No Charge for Preventive Care Visits.	Preventive care is available only to Members age 19 and under and is subject to Deductible and 20% Coinsurance.
	$10 per visit for treatment of illness or injury.	Office or home visits for treatment of illness or injury are Covered subject to Deductible and 20% Coinsurance. Some procedures require Precertification. Please see your Certificate.
	Two well-woman examinations, Pap tests, and age appropriate mammograms are Covered No Charge.	Female Members may receive an annual Pap test or age appropriate mammogram subject to Coinsurance and Deductible. Well-woman examinations are not Covered.
Inpatient Hospital Visits	No Charge.	Covered subject to Deductible and 20% Coinsurance.

* The In-Network benefits are provided through your HMO Certificate of Coverage and Member Handbook issued to you by Oxford Health Plans (NY) Inc. In order for a Covered Service to be Covered In-Network, the service must be obtained in accordance with terms and conditions of the HMO Certificate. All Covered Services must be provided or arranged by the Member's PCP or Network Provider of OB/GYN care.

** The Out-of-Network benefits are provided through your Supplemental Certificate of Coverage and Member Handbook issued to you by Oxford Health Insurance, Inc. Covered Services are reimbursed only in accordance with its terms and conditions.

IMPORTANT: PLEASE REVIEW MAXIMUMS AND LIMITATIONS (PAGES 8 & 9)

COVERED SERVICES	IN-NETWORK	OUT-OF-NETWORK
Primary and Preventive Care (cont.)		
Diabetes Education and Self-Management	$10 per visit.	Covered subject to Deductible and 20% Coinsurance.
Diabetic Supplies	The lesser of the PCP Office Visit Copayment or 20% of the cost of the item.	Covered subject to Deductible and 20% Coinsurance. Precertification is required for the purchase of an insulin pump.
Specialty Care		
Physician Office and Home Visits	$10 per visit.	Covered subject to Deductible and 20% Coinsurance. Some procedures require Precertification. Please see your Certificate.
Inpatient Hospital Visit	No Charge.	Covered subject to Deductible and 20% Coinsurance.
Obstetrical Services (Including prenatal and postnatal)	$10 per initial visit.	Covered subject to Deductible and 20% Coinsurance. Precertification is required.
Elective termination of Pregnancy	No Charge. We pay a maximum benefit of $350 per procedure.	Covered subject to Deductible and 20% Coinsurance. We pay a maximum benefit of $350 per procedure.

COVERED SERVICES	IN-NETWORK	OUT-OF-NETWORK
Specialty Care (cont.)		
Treatment of Infertility		
Specialist Office Visit	$10 per visit.	IN-NETWORK BENEFIT ONLY
Outpatient Facility Services	No Charge.	IN-NETWORK BENEFIT ONLY
Allergy Testing and Treatment	$10 per visit.	Covered subject to Deductible and 20% Coinsurance.
Rehabilitation Services (Physical, Speech and Occupational)		
Outpatient	$10 per visit.	Covered subject to Deductible and 20% Coinsurance.
Inpatient	No Charge.	Covered subject to Deductible and 20% Coinsurance. Precertification is required.
Oral Surgery	No Charge.	Covered subject to Deductible and 20% Coinsurance. Precertification is required.
Pediatric Preventive Dental (Through age 11)	No Charge.	The services of Non-Network dentists are Covered under the terms of the HMO Certificate.
Laboratory Procedures and X-ray Examinations	No Charge.	Covered subject to Deductible and 20% Coinsurance. Precertification is required for PET scans, MRA's and endoscopic procedures.
Diagnostic Mammography	No Charge.	Covered subject to Deductible and 20% Coinsurance.

COVERED SERVICES	IN-NETWORK	OUT-OF-NETWORK
Specialty Care (cont.)		
Prosthetic Devices	No Charge for an internal prosthetic device.	No charge for an internal prosthetic device. Surgery is subject to Hospital Deductible and Coinsurance.
	External Devices have no Copayment.	External devices are subject to Deductible and 20% Coinsurance. Precertification is required before purchase.
Transplants	Transplants are performed at Our approved facilities are Covered subject to the Inpatient Hospital Copayment. Transplants performed elsewhere are not Covered.	Covered subject to Deductible and 20% Coinsurance. Precertification is required.
Home Health Services	$10 per visit.	Covered subject to 20% Coinsurance. Not subject to Deductible. Precertification is required.
Chiropractic Care	$10 per visit.	Covered subject to Deductible and 20% Coinsurance.
Second Opinions	At your request $10 per visit. At our request, no charge.	Covered subject to Deductible and 20% Coinsurance.
Durable Medical Equipment	No Charge.	Covered subject to Deductible and 20% Coinsurance. Precertification is required on items that cost $500 or more.

COVERED SERVICES	IN-NETWORK	OUT-OF-NETWORK
Hospital and Other Facility Based Services		
Inpatient Hospital Services	No Charge.	Covered subject to Deductible and 20% Coinsurance per continuous confinement. Precertification is required.
Outpatient Hospital Services and Ambulatory Surgical Center Services	No Charge.	Covered subject to Deductible and 20% Coinsurance. Precertification is required.
Skilled Nursing Facility Services	No Charge.	Covered subject to Deductible and 20% Coinsurance. Precertification is required.
Hospice Services		
Inpatient	No Charge.	Covered subject to Deductible and 20% Coinsurance per continuous confinement. Precertification is required.
Outpatient	No Charge.	Covered subject to Deductible and 20% Coinsurance. Precertification is required.
Home Health Care	$10 per visit.	Covered subject to 20% Coinsurance. Not subject to Deductible. Precertification is required.
Skilled Nursing Facility Services	No Charge.	Covered subject to Deductible and 20% Coinsurance. Precertification is required.

COVERED SERVICES	IN-NETWORK	OUT-OF-NETWORK
Alcohol and Substance Abuse Services		
Outpatient Alcohol and Substance Abuse Rehabilitation	No Charge.	Covered subject to Deductible and 20% Coinsurance. Precertification is required.
Medical Emergency and Urgent Care Services		
Emergency Room Services	$50 per visit (Waived if a Member becomes confined in a Hospital).	When proper notice is not given, Medical Emergencies are Covered as described in the Supplemental Certificate subject to Deductible and 50% Coinsurance.
Urgent Care Facility Services	When proper notice is given, Non-Network Providers will be covered. $10 per visit (Waived if a Member becomes confined in a Hospital).	Covered subject to Deductible and 20% Coinsurance.
Ambulance Services	No Charge.	All Covered Ambulance Services will be Covered as an In-Network benefit.
Supplemental Coverage		
Mental Health Services		
Inpatient	No Charge.	COVERED IN-NETWORK ONLY.
Mental Health Services		
Outpatient	50% copayment.	After deductible, maximum $25 payment per visit.

COVERED SERVICES	IN-NETWORK	OUT-OF-NETWORK
Supplemental Coverage (cont.)		
Alcohol and Substance Abuse Services		
Detoxification	No Charge.	COVERED IN-NETWORK ONLY.
Inpatient Services	No Charge.	COVERED IN-NETWORK ONLY.
Prescription Drugs	$5 copay per generic prescription $15 copay per preferred brand prescription $50 copay per brand name prescription (includes oral contraceptives)	Not Covered.

Important:

Coverage under the supplemental Certificate does not duplicate coverage under the HMO Certificate. Benefits are not cumulative. Benefits received under the Supplemental Certificate reduce the amount of benefits available under the HMO Certificate and Benefits received under the HMO Certificate reduce the amount of benefits available under the Supplemental Certificate.

MAXIMUMS AND LIMITATIONS

Unless otherwise indicated, the following maximums and limitations apply to both the In-Network and Out-of-Network Benefits combined.

All reimbursements for Out-of-Network benefits are subject to UCR.

Out-of-Network Benefits	Out-of-Network benefits are unlimited during the entire time the member is covered.	
Diabetes Supplies	Diabetic Supplies will only be supplied in amounts consistent with the Member's treatment plan as developed by the Member's Physician. Only basic Models of blood glucose monitors are Covered unless the Member has special needs relating to poor vision or blindness.	
Elective Termination of Pregnancy	There is no maximum limit on number of procedures performed per Contract year. We pay a maximum benefit of $350 per procedure.	
Treatment of Infertility	We Cover only one cycle of Advanced Infertility Treatment. This includes one egg harvesting and one transfer during a two-year period. The maximum benefit is $10,000 per member, per lifetime. This benefit is available only In-Network.	
Rehabilitative Therapy Services (physical, speech and occupational therapy)	Inpatient Rehabilitation:	One consecutive 60-day period per condition, per lifetime.
	Outpatient Rehabilitation:	90 visits per condition, per lifetime.
Transplants	In-Network Coverage is available only at facilities specifically approved and designated by Oxford Health Plans (NY), Inc. to perform these procedures.	
Home Health Services	60 visits per Contract Year.	
Chiropractic Services	In-Network: Subject to Medical Necessity, unlimited. Referral required from gatekeeper.	
	Out-of Network: Subject to Medical Necessity, unlimited.	
Exercise Facility Reimbursement	We will reimburse a Subscriber $100 per six-month period. We will reimburse the Subscriber's spouse $50 per six-month period. The Member must complete 50 visits within the six-month period.	

MAXIMUMS AND LIMITATIONS

Skilled Nursing Facility Services	30 days per Calendar year.
Hospice Services	210 days.
Bereavement Counseling for the Member's family	5 sessions either before or after the death of the Member.
Outpatient Alcoholism and Substance Abuse Rehabilitation	60 visits per Calendar Year. Up to 20 of these visits may be used by the Member's family.
Supplemental Rider Information	
Mental Health Services	
Inpatient	30 days per Calendar Year.
Outpatient	**Out-of-Network:** 30 outpatient visits to a maximum payment of $750 per Calendar Year. **In Network:** 30 outpatient visits.
Alcoholism and Substance Abuse Services	
Detoxification	7 days per Calendar Year.
Inpatient Services	30 days per per Calendar Year.

FAILURE TO PRECERTIFY

If you fail to obtain Precertification for an Out-of-Network benefit, you will be subject to a reduction in benefits. You must pay 50% of the costs for such service or supply.

DEDUCTIBLE

The applicable Deductibles for this Plan are:

Individual: $250
Family: $625

OUT-OF-POCKET LIMITS

The maximum amount you must pay in any Calendar Year for Out-of-Network Covered Services is: $1,250 for an individual and $3,125 for a family.

Remember, only Coinsurance and the amounts paid to meet your Deductible count toward the Out-of-Pocket Maximum. Copayments for In-Network benefits, amounts in excess of the UCR, and amounts paid for non-Covered Services, and any amounts paid as a penalty do not count toward the Out-of-Pocket Maximum. Coinsurance paid for any Covered Service obtained under a Supplemental Rider (excluding State mandated offers) will not be applied to the Out-of-Pocket maximum.

COPAYMENT LIMITS

Total Copayments paid by or on behalf of a Member during a Calendar Year shall not exceed 200% of the total annual Premium Rate for individual or family coverage, whichever is applicable for services provided under the HMO Certificate in any Calendar Year, provided application is made to the HMO by a Member within 45 days of the end of the Calendar Year to which such limitation applies. Any excess in the amount of payments will be refunded to the Member.

Copayments paid for any Covered Service obtained under a Supplemental Rider (excluding State mandated offers), will not be applied toward the Copayment Limits.

ELIGIBILITY LIMITS

The limiting ages for dependents (as defined in the HMO Certificate) are: under the age of 19 and between the ages of 19 and 23 for a full time student.

IMPORTANT: this document is not a contract. It is only a summary of your coverage under the Freedom Plan. Please read your HMO Certificate and your Supplemental Certificate for a full description of your Covered Services, exclusions and other terms and conditions of coverage.

Dear Member,

Welcome, and thank you for selecting Oxford Health Plans.

Oxford wants to play an active role in your life and health by bringing quality, choice, and service to a higher level. We call this being a healthcare catalyst—where our access to a quality network, preventive programs, and practical resources are all working together to help move you to a healthier place. As an Oxford Member you have access to:

- An extensive provider network* consisting of more than 50,000 physician office locations and 200 of the area's finest hospitals.
- Discounted rates on services from over 2,400 credentialed alternative medicine providers (including acupuncturists, chiropractors, and massage therapists).
- Healthcare guidance from experienced nurses 24 hours a day, 365 days a year; *Oxford On-Call®*.
- Oxford's award-winning web site, *www.oxfordhealth.com*, which allows you to conduct your business transactions on your time, not ours.

Enclosed is your new Summary of Benefits, Certificate of Coverage, and other important plan information. If you have questions about your coverage, please log on to *www.oxfordhealth.com* or call Customer Service at the number on your Oxford ID card.

To learn more about Oxford's programs that can help you achieve your best state of health, visit our web site at *www.oxfordhealth.com.*

Wishing you the best of health.

Sincerely,

Norman C Payson MD

Norm C. Payson, MD
Chief Executive Officer

*Exact number of provider office locations varies by state, line of business and plan design.

MS-02-179

Oxford Health Plans

IMPORTANT

This booklet contains your Certificates of Coverage and explains your new healthcare coverage. As a Member of the Oxford Freedom Plan®, each time you see a doctor you have the choice of seeking care on an In-Network basis through your Oxford primary care physician or on an Out-of-Network basis. In order to thoroughly explain your coverage, We provide you with TWO DIFFERENT CERTIFICATES, one for In-Network and one for Out-of-Network benefits.

In-Network Coverage

If you receive care from your Oxford Primary Care Physician or from an Oxford Network Specialist with an authorized referral, you are eligible for "In-Network" coverage. Your In-Network benefits and coverage are explained in the first half of your handbook. This part of your handbook has its own Table of Contents and "Getting Started" guide to your In-Network benefits.

Out-of-Network Coverage

If you receive Covered Services from a physician other than your Oxford Primary Care Physician, or from an Oxford Network Specialist without an authorized referral, you are eligible for "Out-of-Network" coverage. Out-of-Network benefits and coverage are explained in the second half of your handbook. This Supplemental Certificate of Coverage restarts with its own Table of Contents and another "Getting Started" guide to your benefits.

Each time you see a doctor, remember to look in the appropriate section of your handbook to determine your exact benefits. If you have any questions or need assistance, Our Customer Service Associates will be happy to help you. They are available at 800-444-6222, Monday through Friday, 8 AM to 6 PM, or after hours at 800-899-9039.

Oxford Health Plans

OXFORD HEALTH INSURANCE, INC.

Supplemental Certificate of Coverage

&

Member Handbook

This Certificate describes your Out-of-Network coverage under the Freedom Plan®.

SUPPLEMENTAL CERTIFICATE OF COVERAGE ("Certificate")

for

Oxford Health Insurance, Inc. ("Oxford")

Please read this entire Certificate carefully, including your Summary of Benefits, which contains information specific to your Group. These documents, and any attached riders, describe your rights and obligations and those of Oxford.

Under this Certificate, you engage Oxford to pay benefits for Covered medical and Hospital services in accordance with the terms and conditions of this Certificate and in reliance upon the statements you made in your application for coverage.

Oxford agrees with the Group to administer the Covered Services set forth in this Certificate, as may be amended from time to time by Oxford or the Group's Board of Directors. **Please note:**

- This Certificate and any riders, schedules or attachments have been delivered in consideration of the Group's timely payment of Premiums.
- No services are Covered under this Certificate in the absence of current payment of Premiums, subject to a 30-day Grace Period and the terms and conditions of the Certificate.
- No services are Covered under this Certificate unless coverage was in force at the time the service was obtained.
- In some instances, a medical procedure may not be Covered or may require Precertification. It is your responsibility to understand the terms and conditions in this Certificate.
- This Certificate cancels and replaces any prior Certificate issued to you by Oxford Health Insurance, Inc., for coverage under the Freedom Plan®.
- This Certificate is not in lieu of and does not affect any requirements for coverage by Workers' Compensation Insurance.
- This Certificate does not constitute the entire Agreement between Oxford Health Insurance, Inc., and the Group. While this Certificate has been made a part of the Group Enrollment Agreement, certain terms and conditions may only be described in the Group Enrollment Agreement itself. If questions arise, the terms of the Group Enrollment Agreement will govern. A copy of the Group Enrollment Agreement is available, upon request, from your employer.

This Certificate is governed by the laws of the State of New York.

issues related to the Member's condition. Hospice Care will be Covered only when provided as part of a Hospice Care program certified by the State of New York. Such certified programs may include Hospice Care delivered by: a Hospital (inpatient or outpatient), Home Healthcare Agency, Skilled Nursing Facility or a licensed Hospice Care facility. Coverage is limited to 210 days.

Coverage is not provided for: funeral arrangements; pastoral, financial or legal counseling; homemaker, caretaker or respite care.

4. ALCOHOLISM AND SUBSTANCE ABUSE

All services under this section require Precertification. You will be responsible for a greater portion of the cost of all services that are not Precertified.

Outpatient services for the diagnosis and treatment of alcoholism or substance abuse are limited to the amount of visits shown in your Summary of Benefits. The summary will also show the amount of visits which may be used by the Member's family. Outpatient services are limited to Hospitals or other facilities which are certified or licensed by the appropriate state regulatory authority.

Coverage for: detoxification for alcoholism and substance abuse; inpatient rehabilitation for alcoholism and substance abuse; inpatient mental health services; and outpatient mental health services are not Covered under this Certificate unless the Group has purchased a rider which adds these benefits. Please check your Summary of Benefits to verify what coverage you have available.

5. MEDICAL EMERGENCIES AND URGENT CARE

Medical Emergencies are Covered under your HMO Certificate regardless of wether they occur in or out of the Service Area. However, in those instances when you fail to access Emergency Care in accordance with the **procedures** required by the HMO (and the HMO denies coverage), coverage will be available under this Certificate, subject to Deductible, the penalty shown in your Summary of Benefits and UCR. This applies only to true Medical Emergencies. Coverage will not be provided when We determine that the use of the emergency room was improper.

Urgent Care services and the use of Urgent Care Centers are Covered under this Certificate, subject to Deductible, Coinsurance and UCR. No Precertification is required. In-Network coverage is available as described in your HMO Certificate.

6. AMBULANCE SERVICES

Medical Emergencies are Covered under your HMO Certificate. Transportation by Ambulance in connection with Medical Emergencies is also Covered under the HMO Certificate. Please check your HMO Certificate to determine what coverage is available.

SECTION IV.
EXCLUSIONS AND LIMITATIONS

Unless coverage is specifically provided under this Certificate or provided under a rider or attachment to this Certificate, the following services and benefits are **not** Covered.

1. Services which are not Medically Necessary. If there is a dispute between a provider and Us about the Medical Necessity of a service or supply, you may appeal Our decision. Any disputed service or supply will not be Covered during the appeal process (please refer to the "Utilization Review Appeal" provision of the HMO Certificate).

2. A portion of the cost of services for which a required Precertification was not obtained.

3. Acupuncture therapy.

4. Adopted newly born infant's initial hospital stay if either of the natural parents has coverage available for the infant's care.

5. Alcohol and substance abuse treatment on an inpatient basis. Detoxification is not Covered.

6. Blood, blood plasma and blood derivatives other than those described as Covered under Section III of this Certificate. Synthetic blood, apheresis or plasmapheresis, the collection and storage of blood or the cost of securing the services of blood donors are not Covered.

7. Birth control pills, implantable contraceptive drugs, condoms, foams or devices, IUDs, diaphragms, contraceptive jellies and ointments, even if they are being prescribed or recommended for a medical condition other than birth control.

8. Care for conditions that by federal, state or local law must be treated in a public facility, including, but not limited to, commitments for mental illness. Additionally, to the extent allowed by law, we do not Cover care or treatment provided in a Hospital that is owned or operated by any federal, state or other governmental entity.

9. Comfort or convenience items, including but not limited to: barber services; guest meals and accommodations; telephone, television or radio charges; travel expenses; or take-home supplies. We also do not Cover the purchase or rental of household fixtures or equipment, including but not limited to: escalators; elevators; swimming pools; exercise cycles; air purifiers; air conditioners; water purifiers; allergenic pillows, mattresses or waterbeds.

10. Cosmetic, plastic or reconstructive surgery which is performed primarily to improve the appearance of any portion of the body, including but not limited to: surgery for sagging of extra skin; any augmentation or reduction procedure (e.g., mammoplasty); liposuction; keloids; rhinoplasty and associated surgery. Complications of such surgery are Covered only if they are Medically Necessary and are otherwise Covered. Remedial surgery is not Covered.

11. Court-ordered services or services that have been ordered as a condition of probation or parole. However, these services may be Covered if We agree that the services are Medically Necessary, the Member has not exhausted his or her benefit for the calendar year, and the treatment is provided in accordance with Our policies and procedures.

12. Custodial care, domiciliary care, long-term care, maintenance care, adult day care or rest cures. We do not Cover room, board, nursing care or personal care which is rendered to assist a Member who, in Our opinion, has reached the maximum level of physical or mental function realistically possible and will not make further significant clinical improvement.

13. Dental services related to the care, filling, removal or replacement of teeth and the treatment of injuries or diseases of the teeth, gums and temporomandibular joint, including but not limited to: apicoectomy, orthodontics, root canals, soft tissue impaction, temporomandibular joint dysfunction therapy, alveolectomy, treatment of periodontal disease or orthognathic surgery. As described in Section III, 2, G, "Oral Surgery," only dental services required to treat accidental injury of sound, natural teeth are Covered.

14. Diabetes; limitations and exclusions. The Covered Services specified in this Certificate are Covered only as follows:

a. The items are Medically Necessary, as determined by Us, and are provided in amounts that are in accordance with a reasonable treatment plan developed by a Physician for the Member.

b. All requests for insulin pumps must first be reviewed by one of Our Medical Case Managers and approved by Our Medical Director.

c. Only basic models of blood glucose monitors will be covered, unless the Member has special needs relating to poor vision or blindness.

The following are not Covered:

a. Membership in health clubs, diet plans, or other organizations, even if recommended by a Physician or a Qualified Health Provider for the purpose of losing weight.

b. Any counseling or courses in diabetes management other than as described in this Certificate. Stays at special facilities or spas for the purpose of diabetes education/management.

c. Special foods, diet aids and supplements related to dieting.

d. Any item that is not both Medically Necessary and prescribed by the Member's Physician or Qualified Health Provider.

15. Durable Medical Equipment: We do not Cover: orthotics, arch supports, corrective shoes, false teeth, hearing aids.

16. Experimental, investigational or ineffective surgical or medical treatments, procedures, drugs, or research studies, including but not limited to: transplants, stem cell retrieval, cancer chemotherapy protocols, AIDS clinical trials or I.V. therapies that are not recognized as acceptable medical practice, and any such services where federal or other governmental agency approval is required but has not been granted. We will make the determination as to whether the requested service is excluded in accordance with this provision. In certain instances, such procedures may be Covered if they are approved in advance by Our Medical Advisory Board and provided in accordance with the provisions of this Certificate.

17. Emergency Care. Emergency Care is Covered only to the extent described in Section III, 5, "Medical Emergencies and Urgent Care," in this Certificate. Also excluded is improper use of an emergency room or emergency admissions. Routine care and treatment for conditions that We determine were not Medical Emergencies, when received in an emergency room, are not Covered.

18. Infertility treatment and supplies (except as otherwise Covered under this Certificate), even if the treatment or supply is for a purpose other than the correction of infertility. Services and supplies that are not Covered include but are not limited to: injectable infertility drugs such as Pergonal, Metrodin, etc., cost for an ovum donor or donor sperm, sperm storage costs, cryopreservation and storage of embryos, ovulation predictor kits, in-vitro services for women who have undergone tubal ligation, any infertility services if the male has undergone a vasectomy, and all costs for and relating to surrogate motherhood (maternity services are Covered for Members acting as surrogate mothers). We also do not Cover services to reverse voluntary sterilizations.

19. Learning and behavioral disorders. Services for the evaluation or treatment (including remedial education) of: learning disabilities or minimal brain dysfunction; mental retardation; developmental and learning disorders or behavioral problems. We also do not Cover behavioral training or cognitive rehabilitation.

20. When Medicare is the primary payor, We Cover the services provided by this Certificate only to the extent they are not Covered under Medicare.

21. Mental Health Services. Please check your Summary of Benefits to see if coverage of these services has been added through a rider.

22. Military service-related conditions. Conditions that are connected with a Member's service in the military and for which the Member is legally entitled to receive services at a government facility.

23. No-fault automobile insurance. Any personal injury benefits payable under mandatory no-fault automobile insurance or for Covered Services which are eligible for payment under the provisions of an automobile insurance contract or pursuant to any federal or state law which mandates indemnification for such services to persons suffering bodily injury from motor vehicle accidents, where permitted by law.

24. Non-eligible institutions. Any services or supplies furnished by a non-eligible institution, which is defined as other than a Hospital or Skilled Nursing Facility, and which is primarily a place of rest, a place for the aged, or any similar institution, regardless of how denominated.

25. Non-medical services and long-term rehabilitation services for physical therapy or the treatment of alcoholism or drug abuse, including rehabilitation services in a specialized inpatient or residential facility, except as specifically Covered under this Certificate.

4. CLAIM INFORMATION

Claims for Covered Services will be paid within 60 days after We receive proof of the claim. If necessary, Our Claims Department will contact you for more information regarding your claim in order to speed up the processing. If you would like to inquire about the status of a claim, call the "Claims" telephone number listed in the front of this Certificate. Please have the date of service and your ID number ready.

5. CLAIM REVIEW (APPEAL)

We will provide you with an explanation for actions taken on each claim that you submit to Us. If you disagree with any decision, you may appeal through the Grievance Procedure, as described in the HMO Certificate.

6. NETWORK PROVIDERS

If you receive Covered Services from a Network Provider but not in accordance with the terms and conditions of the HMO Certificate, coverage will be provided under this Certificate. When you see a Network Provider under these circumstances, the Covered Services will be treated as if they were delivered by a non-Network Provider, and you must file a claim, as described above.

SECTION IX.
OTHER IMPORTANT DOCUMENTS

1. SUPPLEMENTAL COVERAGE BY RIDER

The terms and conditions of this Certificate are subject to revision, addition, or deletion. Any such changes will be made by a rider. The terms of a rider that is issued by Us and accepted by the Group will supersede conflicting terms in this Certificate. Riders that are part of your Plan will be issued with your Certificate. You should check your Summary of Benefits or verify with the Group whether your Plan is subject to any rider.

Please check with your Benefits Administrator to make sure you have the most recent documents concerning your supplemental coverage under the Plan.

2. SUMMARY OF BENEFITS

In order to receive Covered Services under this Certificate, We may require that you pay a set percentage of charges (Coinsurance) to the provider who supplied the Covered Services. In addition, certain other charges, such as a Deductible, may be applied. You will receive a Summary of Benefits that will explain when Coinsurance and other similar features of your Plan will be applied. It will also inform you of any applicable benefit maximums (e.g., limits on days, visits or amounts payable).

Please check with your Benefits Administrator to make sure you have the most recent documents concerning your supplemental coverage under the Plan.

SECTION XI.
GENERAL PROVISIONS

1. Entire Agreement. This Certificate, the HMO Certificate, the Freedom Plan® Summary of Benefits, any Certificate riders issued to and accepted by the Group, the Group Enrollment Agreements, and the individual applications of you and your Covered Dependents, if any, constitute the entire contract between the parties and, as of the effective date hereof, supersede all other agreements between the parties. Any and all statements made to Us by the Group and any Subscriber or Covered Dependent will, in the absence of fraud, be deemed representations and not warranties, and no such statement, unless it is contained in a written application for coverage under this Certificate, shall be used in defense to a claim under this Certificate.

2. Form or Content of Certificate. No agent or employee of Us is authorized to change the form or content of this Certificate. Such changes can be made only through an endorsement authorized and signed by one of Our officers.

3. Identification Cards. Cards issued by Us to Members are for identification only. Possession of an identification card confers no right to services or other benefits, under this Certificate. To be entitled to such services or benefits the holder of the card must, in fact, be a Member on whose behalf all applicable Premiums under this Certificate and the HMO Certificate have actually been paid. Any person receiving services or other benefits to which he is not then entitled pursuant to the provisions of this Certificate will be liable for the actual cost of such services or benefits.

4. Notice. Any notice required under this Certificate may be given to Us by U.S. Mail, first class, postage prepaid, to the Customer Service address listed in the front of the Certificate. Notice to a Member will be sent to the last address We have for that Member. Member agrees to provide Us with notice, within 31 days, of any change of address.

5. Interpretation of Certificate. The laws of the State of New York shall be applied to interpretations of this Certificate.

6. Assignment. This Certificate is not assignable by Group without Our written consent. Any benefits under this Certificate are not assignable by any Member without Our written consent. In addition, This Agreement shall not confer any rights or obligations on third parties except as specifically provided herein.

7. Gender. The use of any gender in this Certificate is deemed to include the other gender, and, whenever appropriate, the use of the singular is deemed to include the plural (and vice versa).

8. Modifications. By this Certificate, the Group makes Our coverage available to Members who are eligible under the terms of the Certificate. However, this Certificate is subject to amendment, modification and termination in accordance with this provision, the Group Enrollment Agreement or by mutual agreement between Us and Group's Board of Directors, without the consent or concurrence of any Member. By enrolling in this Plan, all Members legally capable of contracting, and the legal representatives of all Members incapable of contracting, agree to all its terms, conditions, and provisions.

9. Clerical Error. Clerical error, whether by the Group or Us, with respect to this Certificate or any other documentation issued by Us in connection with this Certificate, or in keeping any record pertaining to the coverage hereunder, will not modify or invalidate coverage otherwise validly in force or continue coverage otherwise validly terminated.

10. Policies and Procedures. We may adopt reasonable policies, procedures, rules and interpretations to promote the orderly and efficient administration of this Certificate with which Members shall comply.

11. Waiver. The waiver by any party of any breach of any provision of the Agreement will not be construed as a waiver of any subsequent breach of the same or any other provision. The failure to exercise any right hereunder will not operate as a waiver of such right.

12. Termination of the Agreement. The Agreement will continue in effect for the period of time specified in the Agreement and may be canceled in accordance with the terms of the Agreement.

13. Incontestability. Except as to a fraudulent misstatement: No statement made by the Group or any Member will be the basis for voiding coverage or denying coverage or be used in defense of a claim unless it is in writing. No statement made by the Group will be the basis for voiding the Agreement after it has been in force for two years from its effective date.

14. Independent Contractors. All providers (Network and non-Network) are independent contractors. They are not Our agents or employees. We and Our employees are not the agent or employee of any provider. We are not liable for any claim or demand on account of damages arising out of, or in any manner connected with, any injuries alleged to be suffered by any Member while receiving care from any provider or in any provider's facility.

15. Limitation on Payment. We will not pay an amount that is more than a provider charged for Covered Services or that is more than the UCR charges, nor will we credit such an amount toward the deductible or Out-of-Pocket Maximum.

Oxford Health Plans®

Oxford Health Insurance, Inc.

Mental Health and Substance Abuse Rider

Your supplemental Certificate of Coverage & Member Handbook ("Certificate") is revised as follows:

I. Coverage

1. Mental Health Services

a. Inpatient

We Cover Inpatient and Equivalent Care for the treatment of mental or nervous disorders. We define "Inpatient Care" to mean treatment provided in a hospital as defined below. "Equivalent Care" is provided in a setting, other than such hospital, that We and the Provider deem to be safe and medically appropriate.

We reserve the right to provide this benefit in the modality We determine to be both medically appropriate and the most cost effective.

Inpatient and Equivalent Care mental health services are Covered only when obtained from facilities licensed by the appropriate state regulatory authority as well as any other Provider We deem appropriate to provide the Medically Necessary level of care. Alcoholism and substance abuse related rehabilitation are not considered mental health services under this provision.

For Inpatient and Equivalent care, We cover up to the amount of days shown in your Summary of Benefits.

b. Outpatient

We cover outpatient visits for the treatment of mental or nervous disorders. A "visit" for the purposes of this provision is 45 to 60 minutes of therapy.

Outpatient mental health services are Covered only when obtained from duly licensed: psychiatrists or practicing psychologists; or by certified social workers or mental hygiene facilities. Alcoholism and substance abuse related rehabilitation are not considered mental health services under this provision.

We Cover up to the amount of visits shown in your Summary of Benefits.

Alcoholism and Substance Abuse

a. Detoxification

Inpatient detoxification is Covered up to the amount of days and admissions shown in your Summary of Benefits.

b. Inpatient Services

Treatment in a Plan Specialized Rehabilitation Facility will be Covered, in accordance with an individual treatment plan prepared by your Provider. Coverage is limited to the amount of days shown in your Summary of Benefits.

II. Precertification

All treatment received under this Rider must be precertified and described in Section I. Of your Certificate.

III. Coinsurance and Benefit Limitations

All covered Services under this Rider are subject to UCR, Deductible and the Coinsurance shown in your Summary of Benefits.

IV. Miscellaneous Provisions

All benefits are on a per Member, per calendar year basis.

The "Exclusions and Limitations," section of your Certificate is amended as follows:

a. The exclusion regarding inpatient alcohol and substance abuse treatment and detoxification is removed from the Certificate.

b. The exclusion regarding mental health services is removed from the Certificate.

This Rider supersedes any amendment or rider providing coverage for Mental Health and Substance Abuse previously issued by Us. In the event of a conflict between the provisions of this Rider and the Certificate, the provisions of this Rider will prevail. All other terms and conditions of the Certificate remain in full force and effect.

Nothing contained in this Rider will be held to vary, alter, waive, or extend any of the terms, conditions, provisions or limitations of the Agreement to which this Rider is attached, other than as specifically stated herein.

EXHIBIT E

Oxford Health Plans (NY), Inc.

Oxford Group Enrollment Agreement

324810 0577

Group Name: Entwistle & Cappucci LLP ("Group")

Group Numbers: EC1227*CSP01 Effective Date: September 1, 2003

Definitions

- Agreement: This Group Enrollment Agreement, the Group Application, the individual applications of the Members, the Certificate of Coverage and Member Handbook, the Summary of Benefits and any applicable Riders.
- OHPNY, Us, We, Our: Oxford Health Plans (NY), Inc.
- Members: Subscribers and Covered Dependents.
- Terms not defined in this Group Enrollment Agreement will have the meaning set forth in the Certificate.

In consideration of the payment of Premiums, OHPNY and Group agree that OHPNY will arrange or pay for Covered medical and hospital services in accordance with the terms and provisions of the Agreement. Such services will be provided for the Group's eligible employees (Subscribers) and their Covered Dependents.

I. EFFECTIVE DATE AND TERMS OF AGREEMENT:

The Agreement will be effective on the 1st of September, 2003 at 12:00 a.m. Eastern Time and will remain in effect for a period of 12 consecutive months, ending on the 31st day of August, 2004 at 11:59 p.m. Eastern Time at which time coverage will terminate (the "Initial Contract Period"). The Agreement, and the coverage provided under the Agreement, will automatically renew after the end of the Initial Contract Period or any Subsequent Contract Period unless it would otherwise terminate in accordance with Section XIII of this Group Enrollment Agreement.

II. COVERAGE:

Benefit Plan Code/Description	Freedom Plan, Freedom Network Very High UCR, $10 copay Deductible: $250 Single/ $625 Family Coinsurance: 80%/20% to $5,000
Optional Benefit Riders:	Prescription Drugs: $7 per generic prescription $20 per preferred brand name $40 per non-preferred brand name

III. PREMIUM RATE SCHEDULE:

324810 0578

Type of Coverage	Total Monthly Premium
Single	$490.14
Family	$1,519.44
Couple	$980.28
Parent/Child(ren)	$931.27

IV. ELIGIBILITY:

Eligible employees of the Group will be full-time employees of the Group who work a minimum of 30 hours per week. In addition, eligible employees of the Group and their eligible family members will meet the eligibility criteria set forth in the Certificate and the requirements set forth below:

Subscribers: Subscribers will be eligible on the date occurring 30 days after commencement of employment. Coverage ends on the date of termination.

Such a waiting period is waived for employees rehired within any time period after an approved leave of absence.

Covered Dependents: The legal spouse of the Subscriber and any unmarried, dependent children, as defined in the Certificate, are eligible for coverage. Such children are eligible only until the child reaches age 19 or age 23 if child is full-time student. Coverage ends on the last day of the Calendar Year.

The eligibility requirements listed in this section of this Group Enrollment Agreement are material to Our administration of the Agreement. During the term of the Agreement, We will not permit any change in these eligibility requirements unless We agree, in writing, to such change.

V. NOTICE:

All notices to be given to the Group's Broker will be addressed to:

All notices to be given to the Group will be addressed to:

Entwistle & Cappucci LLP
299 Park Ave
Floor 14th
New York, NY 10171
Attn: Marsha Boyle

All notices to be given to Us will be addressed to:
Oxford Health Plans (NY), Inc.
10 Tara Boulevard
Nashua NH 03062

VI. PREMIUM DUE DATE AND PAYMENTS:

The first day of the month is the "Premium Due Date." The Group agrees to remit to Us on or before the Premium Due Date the applicable Total Monthly Premium set forth in Section III above for each Member enrolled as of such date. Membership as of such date will be determined by Us in accordance with Our Member records. If a Premium payment is not made in full by Group on or prior to the Premium Due Date, a 30-day Grace Period will be granted to the Group for payment without interest charge. If payment is not received by the expiration of the Grace Period, then the Agreement may be terminated by Us pursuant to Section XIII of this document. Premiums outstanding subsequent to the end of the Grace Period will be subject to a late penalty charge of 1.50% of the total Premium amount due. This amount will be calculated for each 30-day period, or portion thereof, that the amount due remains outstanding. If the Agreement is terminated for any reason, the Group will continue to be held liable for all Premium payments due and unpaid before the termination, including, but not limited to, Premium payments for any time the Agreement is in force during the Grace Period.

Notwithstanding any language to the contrary in the Agreement, We will have no obligation to provide benefits or pay claims for any Member during any period for which the required Premium payment has not been made, including during any Grace Period. If We provide benefits or pay claims for any Member during any period for which the Premium payment has not been made, such provisions of benefits or payment of claims will not constitute a waiver of Our right to discontinue the provision of coverage or payment of claims until such time as the Premium payment is made.

VII. PREMIUM ADJUSTMENTS:

A. Enrollment. If a Member enrolls on or before the fifteenth (15th) day of a month, the Group will remit to Us on or before the next Premium Due Date an additional Total Monthly Premium for such Member for the month in which the Member enrolled. If a Member enrolls after the fifteenth (15th) day of a month, no additional Premium payment will be due for such Member for the month in which the Member enrolled. Note: This does not apply to any Group where the Subscribers become eligible for coverage on the first day of the month, per Section IV, "Eligibility."

B. Termination. If a Member's coverage ends on or before the fifteenth (15th) day of a month, We will credit the Group the total Monthly Premium for such Member for that month. If a Member's coverage ends after the fifteenth (15th) day of a month, the Group will not be entitled to any Premium adjustment from Us. Note: This does not apply to any Group whose Subscriber's lose coverage on the last day of the month, per Section IV, "Eligibility."

VIII. PREMIUM RATE CHANGES:

Initial Contract Period: The Premium Rate Schedule set forth on page one of this Group Enrollment Agreement will be valid only for the Initial Contract Period. Premium Rates for the Initial Contract Period will not be changed by Us unless a change required by statute or regulation increases Our cost risk under the Agreement. If such a statutory or regulatory change occurs, We may change the Premium Rate Schedule at any time with a 45-day prior written notice to Group.

Subsequent Contract Period: At any time, with a 45-day prior written notice, We may change the Premium Rate Schedule for any Subsequent Contract Period as follows:

- Upon the renewal of the Agreement; and
- When a change required by statute or regulation that increases Our risk under the Agreement.

We may also change the Premium Rate for any other reason upon a 90-day prior written notice to the Group.

Regarding renewals: If We fail to give the Group the required advance notice, the Premium Rates in effect prior to the commencement of the Subsequent Contract Period will remain in effect for a period of 45 days after the Group was notified by Us of the new Premium Rates for the Subsequent Contract Period, after which period the new Premium Rates will go into effect.

Any change in the Premium Rates will be subject to the approval of the New York Insurance Department.

IX. MEMBER EFFECTIVE DATES OF COVERAGE:

Coverage of prospective Members will be subject to Our receipt of an Enrollment Form and applicable monthly Premium for each prospective Member within 31 days of the Member becoming eligible for coverage under the Agreement.

X. INELIGIBLE MEMBERS:

If the Group fails to immediately notify Us of a Member's ineligibility, and the Group has made or continues to make the Premium payments for such Member, We will credit such Premium payment back to the last day of the month immediately prior to the month in which such termination notice is received by Us. We will provide this credit only if We have not authorized or incurred claims for health services for such Member during the period when We were unaware of the Member's ineligibility.

XI. OPEN ENROLLMENT PERIOD:

The Group will hold a Group Open Enrollment Period at least once each year. During the Group Open Enrollment Period, eligible employees, as determined by the Agreement, may elect coverage under the Agreement.

XII. RESPONSIBILITIES OF GROUP:

Group agrees to:

A. Offer coverage to eligible employees and their eligible family members, as described in Section IV above. It is agreed that eligible employees of the Group will be free to choose Our coverage or any other coverage as may be available through the Group during the initial and subsequent Group Open Enrollment Periods. Every eligible employee of the Group will be given a fair opportunity to elect one of the Group's coverage options and will not be penalized by the Group because of his or her choice.

B. Offer each new employee the opportunity to elect Our coverage as a procedure of employment when he or she becomes an eligible employee as described in the Agreement.

C. Provide notification to each Member, within 15 days after termination of the Member's coverage, of the Member's right to convert to one of Our individual direct payment contracts, contingent upon the Member having reasonable access to Our Service Area.

D. Furnish to Us, on a monthly basis (or as otherwise required), on Our approved forms, such information as may reasonably be required by Us for the administration of the Agreement, including any change in a Member's eligibility status. In addition, We may, at reasonable times, examine the Group's pertinent records with respect to eligibility and Premium payments hereunder.

E. Comply with all policies and procedures established by Us in administering and interpreting the Agreement.

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XIII. TERMINATION:

A. The Agreement may be terminated by Us:

(i) Upon written notice, if any Premium payment or contribution required to be made by the Group is not received by the Premium Due Date, subject to a 30-day grace period;

(ii) Upon written notice, if the Group ceases to operate or relocates outside of the Service Area;

(iii) If the Group has performed an act or practice that constitutes fraud or made an intentional misrepresentation of material fact under the terms of the Agreement;

(iv) We cease offering group contracts in New York in accordance with applicable law;

(v) The Group ceases to meet the requirements for a group as defined under applicable law [or fails to meet participation requirements];

(vi) In connection with this Plan, there is no longer any employee or dependent who lives, resides, or works in the Service Area; or

(vii) For such other reasons as are acceptable to the Superintendent of Insurance and not inconsistent with Public Law 104-191.

B. The Agreement may be terminated by the Group:

(i) Upon written notice, in the event of the insolvency or bankruptcy of OHPNY;

(ii) Upon written notice, in the event of the revocation of OHPNY's Certificate of Authority;

(iii) In the event of Our material breach of any of the terms and provisions of the Agreement, upon a 45-day prior written notice to Us;

(iv) As of the date any Premium change would become effective, by providing Us with written notice of termination not less than [30] days prior to such effective date; or

(v) Without cause, by giving Us a [60-day] advance written notice.

XIV. ENTIRE AGREEMENT:

The Agreement constitutes the entire agreement between the parties and supersedes all prior and contemporaneous arrangements, understandings, negotiations and discussions of the parties with respect to the subject matter hereof, whether written or oral; and there are no warrantees, representations, or other agreements between the parties in connection with the subject matter hereof, except as specifically set forth herein. No supplement, modification or waiver of the Agreement will be binding unless executed in writing by authorized representatives of the parties.

XV. APPLICABLE LAW:

The Agreement will be governed by the laws of the State of New York.

XVI. INCONSISTENCY:

In the event of any inconsistency between this Group Enrollment Agreement and the Certificate, the terms of this Group Enrollment Agreement will govern.

XVII. AMENDMENTS:

Any amendments to the Agreement must be in writing and must be approved by authorized representatives of both the Group and OHPNY. No other individual has the authority to modify the Agreement, waive any of its provisions or restrictions, extend the time for making payment, or bind OHPNY by making any other commitment or representation.

Formal acceptance of an amendment to the Agreement by the Group will not be required if: the change has been negotiated by means of a request by the Group and agreed to by Us and such amendment is attached to this Group Enrollment Agreement; if the change is required to bring the Agreement into conformance with any applicable law, regulation or ruling of the jurisdiction in which the Agreement is delivered or of the federal government; or if the Group makes payment of any applicable Premium on and after the effective date of such amendment.

[redacted]0582

OXFORD HEALTH PLANS (NY), INC.

BY: _____

Authorized Signature

Kevin Appleton

TITLE: Vice President, Customer Service

DATE: SEP 04 2003

Entwistle & Cappucci LLP

(Group)

BY: _____

Authorized Signature

TITLE: Mng Ptnr

DATE: 8/24/2003

Exhibit F

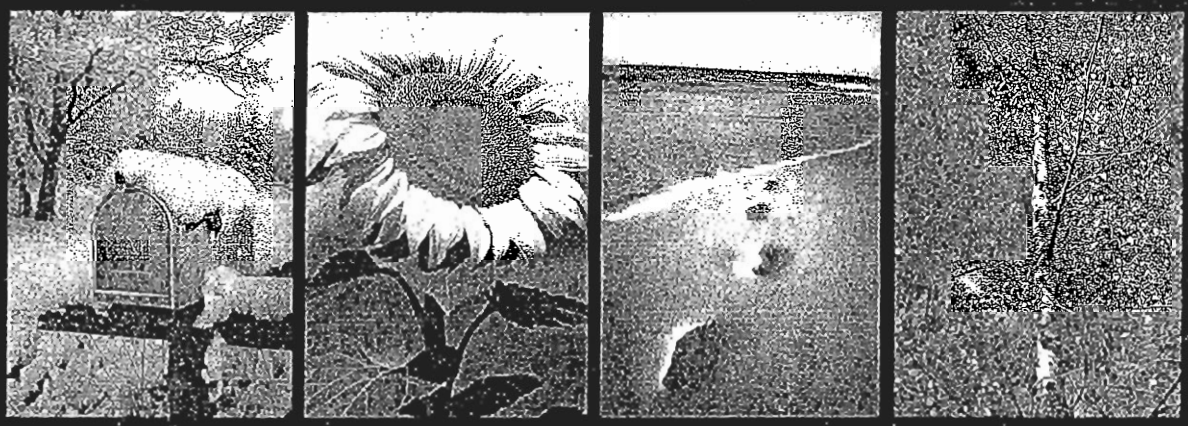
Pursuant to Rule 5 of the United States District Court for the Southern District of New York Procedures For Electronic Case Filing only excerpts of the referenced document have been electronically filed due to the volume of the exhibit.

(This exhibit has been Bates Stamped and a complete copy is being served on plaintiff.).

This filing is without prejudice to any parties' right to supplement the exhibit or file the complete document.

9/1/03

for all seasons



OXFORD HEALTH PLANS®

A UnitedHealthcare Company

REDACTED

EC1227_CSP01

1050 FIFTH AVENUE

NEW YORK, NY 10028

FREEDOM PLAN®

OXFORD HEALTH PLANS®

A UnitedHealthcare Company

14 Feb 2008
2184 (07/05)

2003 CERT 002

Oxford Health Plans®

Dear Oxford Member,

Welcome, and thank you for selecting Oxford Health Plans.

Oxford wants to play an active role in your life and health by bringing quality, choice, and service to a higher level. We call this being a healthcare catalyst—where our access to a quality network, preventive programs, and practical resources are all working together to help you move to a healthier place. As an Oxford Member you have access to:

- A comprehensive network of doctors and hospitals
- Healthcare guidance 24 hours a day, seven days a week, from Oxford's registered nurses through *Oxford On Call®*
- *www.oxfordhealth.com,* Oxford's award-winning web site, which allows you to conduct transactions (e.g., request an ID card, change your primary care physician) and access health information quickly and easily
- A credentialed network of 2, 400 complementary and alternative medicine providers in Connecticut, New York, and New Jersey—including acupuncturists, chiropractors, nutritionists, message therapists, etc.
- Healthy Mind Healthy Body® magazine, your source for health information on prevention, nutrition, and exercise, as well as important benefit and coverage information

Enclosed is your new Summary of Benefits, Certificate of Coverage, and other important plan information. If you have questions about your coverage, please log in to *www.oxfordhealth.com* or call Customer Service at the number on your Oxford ID card.

To learn more about Oxford's programs that can help you achieve your best state of health, visit our web site at *www.oxfordhealth.com.*

Wishing you the best of health.

Sincerely,

Chuck Berg
Chief Executive Officer

Enclosures

OXFORD HEALTH INSURANCE (NY), INC.

FREEDOM PLAN

SUMMARY OF BENEFITS

Entwistle & Cappucci LLP

COVERED SERVICES	IN-NETWORK *	OUT-OF-NETWORK **
Primary and Preventive Care	Physician Office and Home Visits	
	No Charge for Preventive Care Visits.	Preventive care is available only to Members age 19 and under and is subject to Deductible and 20% Coinsurance.
	$10 copay per visit for the treatment of illness or injury	Office or home visits for treatment of illness or injury are Covered subject to Deductible and 20% Coinsurance. Some procedures require Precertification. Please see your Certificate.
	Two well-woman examinations per Calendar Year. Pap tests, and age appropriate mammograms are Covered at No Charge.	Female Members may receive an annual Pap test and/or age appropriate mammogram subject to Coinsurance and Deductible. Well-woman examinations are not Covered.
Inpatient Hospital Visits	No Charge.	Covered subject to Deductible and 20% Coinsurance.

* The In-Network benefits are provided through your HMO Certificate of Coverage & Member Handbook issued to you by Oxford Health Plans (NY) Inc. In order for a Covered Service to be Covered In-Network, the service must be obtained in accordance with terms and conditions of the HMO Certificate.
All Covered Services must be provided or arranged by the Member's PCP or Network Provider of OB/GYN care.

** The Out-of-Network benefits are provided through your Supplemental Certificate of Coverage and Member Handbook issued to you by Oxford Health Insurance, Inc. Covered Services are reimbursed only in accordance with its terms and conditions.

IMPORTANT: PLEASE REVIEW MAXIMUMS AND LIMITATIONS (PAGES 8 & 9)

COVERED SERVICES	IN-NETWORK	OUT-OF-NETWORK
Primary and Preventive Care (cont.)		
Diabetes Education and Self-Management	$10 copay per visit	Covered subject to Deductible and 20% Coinsurance.
Diabetic Supplies	The lesser of the PCP Office Visit Copayment or cost of the item.	Covered subject to Deductible and 20% Coinsurance. **Precertification is required for the purchase of an insulin pump.**
Specialty Care		
Physician Office and Home Visits	$10 copay per visit	Covered subject to Deductible and 20% Coinsurance. **Some procedures require Pre-certification.** Please see your Certificate.
Inpatient Hospital Visit	No Charge.	Covered subject to Deductible and 20% Coinsurance.
Obstetrical Services (Including prenatal and postnatal)	$10 copay per initial visit	Covered subject to Deductible and 20% Coinsurance. Precertification is required.
Elective termination of Pregnancy	No Charge. We pay a maximum benefit of $350 per procedure.	Covered subject to Deductible and 20% Coinsurance. We pay a maximum benefit of $350 per procedure.

COVERED SERVICES	IN-NETWORK	OUT-OF-NETWORK
Specialty Care (cont.)		
Allergy Testing and Treatment	$10 copay per visit	Covered subject to the Deductible and 20% Coinsurance.
Rehabilitation Services (Physical, Speech and Occupational Therapy)		
Outpatient	$10 copay per visit	Covered subject to the Deductible and 20% Coinsurance.
Rehabilitation Services		
Inpatient	No Charge	Covered subject to the Deductible and 20% Coinsurance. **Precertification is required.**
Oral Surgery	No Charge.	Covered subject to the Deductible and 20% Coinsurance. **Precertification is required..**
Pediatric Preventive Dental (Through age 11)	No Charge.	The services of Non-Network dentists are Covered under the terms of the HMO Certificate.
Laboratory Procedures and X-ray Examinations	No Charge.	Covered subject to the Deductible and Coinsurance. Precertification is required for PET scans, MRAs and surgical endoscopic procedures.
Diagnostic Mammography	No Charge.	Covered subject to the Deductible and 20% Coinsurance.

COVERED SERVICES	IN-NETWORK	OUT-OF-NETWORK
Specialty Care (cont.)		
Prosthetic Devices	No charge for an internal prosthetic device.	No charge for an internal prosthetic device.
	External Devices have no Copayment.	Covered subject to the Deductible and 20% Coinsurance. **Precertification is required before Purchase.**
Durable Medical Equipment	No Charge	Covered subject to the Deductible and 20% Coinsurance. **Precertification is required on items that cost $500 or more.**
Transplants	Transplants are performed at Our approved facilities are Covered subject to the Inpatient Hospital Copayment. Transplants performed elsewhere are not Covered.	Covered subject to the Deductible and 20% Coinsurance. **Precertification is required.**
Home Health Services	$10 copay per visit	Covered subject to to 20% Coinsurance. Not subject to Deductible. **Precertification is required.**
Chiropractic Services	$10 copay per visit	Covered subject to the Deductible and 20% Coinsurance.
Second Opinions	At your request $10 copay per visit At our request, no charge.	Covered subject to the Deductible and 20% Coinsurance.

COVERED SERVICES	IN-NETWORK	OUT-OF-NETWORK
Hospital and Other Facility Based Services		
Inpatient Hospital Services	No Charge	Covered subject to the Deductible and 20% Coinsurance per continuous confinement. **Precertification is required.**
Outpatient Hospital Services and Ambulatory Surgical Center Services	No Charge.	Covered subject to the Deductible and 20% Coinsurance **Precertification is required.**
Skilled Nursing Facility Services	No Charge	Covered subject to the Deductible and 20% Coinsurance per continuous confinement. **Precertification is required.**
Hospice Services		
Inpatient	No Charge	Covered subject to the Deductible and 20% Coinsurance. **Precertification is required.**
Outpatient	No Charge.	Covered subject to the Deductible and 20% Coinsurance. **Precertification is required.**
Home Health Care	$10 copay per visit	Covered subject to to 20% Coinsurance. Not subject to Deductible. **Precertification is required.**
Skilled Nursing Facility Services	No Charge	Covered subject to the Deductible and 20% Coinsurance. **Precertification is required.**

	IN-NETWORK	OUT-OF-NETWORK
Alcohol and Substance Abuse Services		
Outpatient Alcohol and Substance Abuse Rehabilitation	No Charge.	Covered subject to the Deductible and 20% Coinsurance. **Percertification is required.**
Medical Emergency Services		
Emergency Room Services	$50 per visit (Waived if a Member becomes confined in a Hospital).	When proper notice is **not** given, Medical Emergencies/Admissions are Covered as described in the Supplemental Certificate subject to Deductible and 50% Coinsurance.
Urgent Care Facility Services	When proper notice is given, the services of Network and Non-Network Providers are Covered at $10 copay per visit. (Waived if a Member becomes confined in a Hospital).	Covered subject to the Deductible and 20% Coinsurance.
Ambulance Services	No Charge.	All Covered Ambulance Services will be Covered as an In-Network benefit.
Supplemental Coverage		
Mental Health Services		
Inpatient	No Charge	COVERED IN-NETWORK ONLY.
Mental Health Services		
Outpatient	50% copayment per visit.	Covered subject to the Deductible and 50% Coinsurance, up to maximum payment of $25 per visit.

COVERED SERVICES	IN-NETWORK	OUT-OF-NETWORK
Supplemental Coverage (cont.)		
Alcohol and Substance Abuse Rehabilitation		
Detoxification	No Charge	COVERED IN-NETWORK ONLY.
Inpatient Services	No Charge	COVERED IN-NETWORK ONLY.
Outpatient Prescription Drugs		**Not Covered**
Includes Oral Contraceptives		
	$7 copay per each Generic Prescription and refill, per 30-day supply	
	$20 copay per each Preferred Brand Prescription and refill, per 30-day supply	
	$40 copay per each Non-Preferred Brand Name Prescription and refill, per 30-day supply	
	When filled at our network Mail Order Pharmacy, You will be charged $14 per Generic Prescription, $40 per each Preferred Brand Prescription and $80 per Non-Preferred Brand Prescription for each 90-day supply of a Prescription Drug	

Important:

Coverage under the Supplemental Certificate does not duplicate coverage under the HMO Certificate. Benefits are not cumulative. Benefits received under the Supplemental Certificate reduce the amount of benefits available under the HMO Certificate and Benefits received under the HMO Certificate reduce the amount of benefits available under the Supplemental Certificate.

MAXIMUMS AND LIMITATIONS

Unless otherwise indicated, the following maximums and limitations apply to both the In-Network and Out-of-Network Benefits combined.

All reimbursements for Out-of-Network benefits are subject to UCR.

Out-of-Network Benefits	Unlimited.	
Diabetic Supplies	Diabetic Supplies will only be supplied in amounts consistent with the Member's treatment plan as developed by the Member's Physician. Only basic models of blood glucose monitors are Covered unless the Member has special needs relating to poor vision or blindness.	
Elective Termination of Pregnancy	We cover one procedure per member, per Calendar Year. We pay a maximum benefit of $350 per procedure.	
Rehabilitative Therapy Services (physical, speech and occupational therapy)	Inpatient Rehabilitation:	One consecutive 60-day period per condition, per lifetime.
	Outpatient Rehabilitation:	90 visits per condition, per lifetime.
Durable Medical Equipment	We will pay a maximum benefit of $1500 per member per calendar year.	
Transplants	In-Network Coverage is available only at facilities specifically approved and designated by Oxford Health Plans (NY), Inc. to perform these procedures.	
Home Health Services	60 visits per Calendar Year.	
Chiropractic Services	**In Network:** Subject to Medical Necessity, unlimited.	
	Out-of-Network: Subject to Medical Necessity, unlimited.	
Exercise Facility Reimbursement	We will reimburse a Subscriber $100 per six-month period. We will reimburse the Subscriber's spouse $50 per six-month period. The Member must complete 50 visits within the six-month period.	

Skilled Nursing Facility Services	30 days per Calendar Year
Hospice Services	210 days.
Bereavement Counseling for the Member's family	5 sessions either before or after the death of the Member.
Outpatient Alcoholism and Substance Abuse Rehabilitation	60 visits per Calendar Year. Up to 20 of these visits may be used by the Member's family.

Supplemental Rider Information

Inpatient Services Alcoholism and Substance Abuse Rehabilitation	30 days per Calendar Year.
Detoxification	7 days per Calendar Year.
Inpatient Mental Health Services	30 days per Calendar Year.
Outpatient Mental Health Services	30 outpatient visits per Calendar Year.

FAILURE TO PRECERTIFY

If you fail to obtain Precertification for an Out-of-Network benefit, you will be subject to a reduction in benefits. You must pay 50% of the costs for such service or supply.

DEDUCTIBLE

The applicable Deductibles for this Plan are:

Individual: $250
Family: $625

OUT-OF-POCKET LIMITS

The maximum amount you must pay in any Calendar Year for Out-of-Network Covered Services is $1250 for an individual and$3125 for a family.Remember, only Coinsurance and the amounts paid to meet your Deductible count toward the Out-of-Pocket Maximum. Copayments for In-Network benefits, amounts in excess of the UCR, amounts paid for non-Covered Services, and any amounts paid as a penalty do not count toward the Out-of-Pocket Maximum.

Coinsurance paid for any Covered Service obtained under a Supplemental Rider (excluding State mandated offers) will not be applied toward the out-of-pocket maximum.

COPAYMENT LIMITS

Total Copayments paid by or on behalf of a Member during a Calendar Year shall not exceed 200% of the total annual Premium Rate for individual or family coverage, whichever is applicable for services provided under the HMO Certificate in any Calendar Year, provided application is made to the HMO by a Member within 45 days of the end of the Calendar Year to which such limitation applies. Any excess in the amount of payments will be refunded to the Member.

Copayments paid for any Covered Service obtained under a Supplemental Rider (excluding State mandated offers), will not be applied toward the Copayment Limits.

ELIGIBILITY

The limiting ages for dependents (as defined in the HMO Certificate) are: under the age of 19 and between the ages of 19 and 23 for a full-time student.

Initial Enrollment (During the initial Group Open Enrollment Period).
Coverage is effective on the effective date of the Agreement.

Newly Eligible Employee (Application within 31 days of becoming eligible).
Coverage is effective as of the date the employee became eligible.

Newly Eligible Dependents (Application within 31 days of becoming eligible).
Coverage is effective as of the date the dependent became eligible. Coverage is effective at birth for newborns and newly born adopted children subject to the enrollment requirements as described in the Certificate.

Group Open Enrollment Period Coverage is effective on the renewal date of the Agreement.

IMPORTANT: This document is not a contract. It is only a summary of your coverage under the Freedom Plan. Please read your HMO Certificate and your Supplemental Certificate for a full description of your Covered Services, exclusions and other terms and conditions of coverage.

Oxford Health Plans

IMPORTANT

This booklet contains your Certificates of Coverage and explains your new healthcare coverage. As a Member of the Oxford Freedom Plan®, each time you see a doctor you have the choice of seeking care on an In-Network basis through your Oxford primary care physician or on an Out-of-Network basis. In order to thoroughly explain your coverage, We provide you with TWO DIFFERENT CERTIFICATES, one for In-Network and one for Out-of-Network benefits.

In-Network Coverage

If you receive care from your Oxford Primary Care Physician or from an Oxford Network Specialist with an authorized referral, you are eligible for "In-Network" coverage. Your In-Network benefits and coverage are explained in the first half of your handbook. This part of your handbook has its own Table of Contents and "Getting Started" guide to your In-Network benefits.

Out-of-Network Coverage

If you receive Covered Services from a physician other than your Oxford Primary Care Physician, or from an Oxford Network Specialist without an authorized referral, you are eligible for "Out-of-Network" coverage. Out-of-Network benefits and coverage are explained in the second half of your handbook. This Supplemental Certificate of Coverage restarts with its own Table of Contents and another "Getting Started" guide to your benefits.

Each time you see a doctor, remember to look in the appropriate section of your handbook to determine your exact benefits. If you have any questions or need assistance, Our Customer Service Associates will be happy to help you. They are available at 800-444-6222, Monday through Friday, 8 AM to 6 PM, or after hours at 800-899-9039.

Oxford Health Plans®

OXFORD HEALTH PLANS (NY), INC

Supplemental Certificate of Coverage
&
Member Handbook

This Certificate describes your Out-of-Network coverage under the Freedom Plan®.

SUPPLEMENTAL CERTIFICATE OF COVERAGE ("Certificate") for Oxford Health Insurance, Inc. ("Oxford")

Please read this entire Certificate carefully, including your Summary of Benefits, which contains information specific to your Group. These documents, and any attached riders, describe your rights and obligations and those of Oxford.

Under this Certificate, you engage Oxford to pay benefits for Covered medical and Hospital services in accordance with the terms and conditions of this Certificate and in reliance upon the statements you made in your application for coverage.

Oxford agrees with the Group to administer the Covered Services set forth in this Certificate, as may be amended from time to time by Oxford or the Group's Board of Directors. Please note:

- This Certificate and any riders, schedules or attachments have been delivered in consideration of the Group's timely payment of Premiums.
- No services are Covered under this Certificate in the absence of current payment of Premiums, subject to a 30-day Grace Period and the terms and conditions of the Certificate.
- No services are Covered under this Certificate unless coverage was in force at the time the service was obtained.
- In some instances, a medical procedure may not be Covered or may require Precertification. It is your responsibility to understand the terms and conditions in this Certificate.
- This Certificate cancels and replaces any prior Certificate issued to you by Oxford Health Insurance, Inc., for coverage under the Freedom Plan®.
- This Certificate is not in lieu of and does not affect any requirements for coverage by Workers' Compensation Insurance.
- This Certificate does not constitute the entire Agreement between Oxford Health Insurance, Inc., and the Group. While this Certificate has been made a part of the Group Enrollment Agreement, certain terms and conditions may only be described in the Group Enrollment Agreement itself. If questions arise, the terms of the Group Enrollment Agreement will govern. A copy of the Group Enrollment Agreement is available, upon request, from your employer.

This Certificate is governed by the laws of the State of New York.

Section IV. Exclusions and Limitations

Unless coverage is specifically provided under this Certificate or provided under a rider or attachment to this Certificate, the following services and benefits are **not** Covered.

1. Services which are not Medically Necessary. If there is a dispute between a provider and Us about the Medical Necessity of a service or supply, you may appeal Our decision. Any disputed service or supply will not be Covered during the appeal process (please refer to the "Utilization Review Appeal" provision of the HMO Certificate).

2. A portion of the cost of services for which a required Precertification was not obtained.

3. Acupuncture therapy.

4. Adopted newly born infant's initial hospital stay if either of the natural parents has coverage available for the infant's care.

5. Alcohol and substance abuse treatment on an inpatient basis. Detoxification is not Covered.

6. Blood, blood plasma and blood derivatives other than those described as Covered under Section III of this Certificate. Synthetic blood, apheresis or plasmapheresis, the collection and storage of blood or the cost of securing the services of blood donors are not Covered.

7. Birth control pills, implantable contraceptive drugs, condoms, foams or devices, IUDs, diaphragms, contraceptive jellies and ointments, even if they are being prescribed or recommended for a medical condition other than birth control.

8. Care for conditions that by federal, state or local law must be treated in a public facility, including, but not limited to, commitments for mental illness. Additionally, to the extent allowed by law, we do not Cover care or treatment provided in a Hospital that is owned or operated by any federal, state or other governmental entity.

9. Comfort or convenience items, including but not limited to: barber services; guest meals and accommodations; telephone, television or radio charges; travel expenses; or take-home supplies. We also do not Cover the purchase or rental of household fixtures or equipment, including but not limited to: escalators; elevators; swimming pools; exercise cycles; air purifiers; air conditioners; water purifiers; allergenic pillows, mattresses or waterbeds.

10. Cosmetic, plastic or reconstructive surgery which is performed primarily to improve the appearance of any portion of the body, including but not limited to: surgery for sagging of extra skin; any augmentation or reduction procedure (e.g., mammoplasty); liposuction; keloids; rhinoplasty and associated surgery. Complications of such surgery are Covered only if they are Medically Necessary and are otherwise Covered. Remedial surgery is not Covered.

11. Court-ordered services or services that have been ordered as a condition of probation or parole. However, these services may be Covered if We agree that the services are Medically Necessary, the Member has not exhausted his or her benefit for the calendar year, and the treatment is provided in accordance with Our policies and procedures.

12. Custodial care, domiciliary care, long-term care, maintenance care, adult day care or rest cures. We do not Cover room, board, nursing care or personal care which is rendered to assist a Member who, in Our opinion, has reached the maximum level of physical or mental function realistically possible and will not make further significant clinical improvement.

13. Dental services related to the care, filling, removal or replacement of teeth and the treatment of injuries or diseases of the teeth, gums and temporomandibular joint, including but not limited to: apicoectomy, orthodontics, root canals, soft tissue impaction, temporomandibular joint dysfunction therapy, alveolectomy, treatment of periodontal disease or orthognathic surgery. As described in Section III, 2, G, "Oral Surgery," only dental services required to treat accidental injury of sound, natural teeth are Covered.

14. Diabetes; limitations and exclusions. The Covered Services specified in this Certificate are Covered only as follows:

a. The items are Medically Necessary, as determined by Us, and are provided in amounts that are in accordance with a reasonable treatment plan developed by a Physician for the Member.

b. All requests for insulin pumps must first be reviewed by one of Our Medical Case Managers and approved by Our Medical Director.

c. Only basic models of blood glucose monitors will be covered, unless the Member has special needs relating to poor vision or blindness.

The following are not Covered:

a. Membership in health clubs, diet plans, or other organizations, even if recommended by a Physician or a Qualified Health Provider for the purpose of losing weight.

b. Any counseling or courses in diabetes management other than as described in this Certificate. Stays at special facilities or spas for the purpose of diabetes education/management.

c. Special foods, diet aids and supplements related to dieting.

d. Any item that is not both Medically Necessary and prescribed by the Member's Physician or Qualified Health Provider.

15. Durable Medical Equipment: We do not Cover: orthotics, arch supports, corrective shoes, false teeth, hearing aids.

16. Experimental, investigational or ineffective surgical or medical treatments, procedures, drugs, or research studies, including but not limited to: transplants, stem cell retrieval, cancer chemotherapy protocols, AIDS clinical trials or I.V. therapies that are not recognized as acceptable medical practice, and any such services where federal or other governmental agency approval is required but has not been granted. We will make the determination as to whether the requested service is excluded in accordance with this provision. In certain instances, such procedures may be Covered if they are approved in advance by Our Medical Advisory Board and provided in accordance with the provisions of this Certificate.

17. Emergency Care. Emergency Care is Covered only to the extent described in Section III, 5, "Medical Emergencies and

Urgent Care," in this Certificate. Also excluded is improper use of an emergency room or emergency admissions. Routine care and treatment for conditions that We determine were not Medical Emergencies, when received in an emergency room, are not Covered.

18. Infertility treatment and supplies (except as otherwise Covered under this Certificate), even if the treatment or supply is for a purpose other than the correction of infertility. Services and supplies that are not Covered include but are not limited to: injectable infertility drugs such as Pergonal, Metrodin, etc., cost for an ovum donor or donor sperm, sperm storage costs, cryopreservation and storage of embryos, ovulation predictor kits, in-vitro services for women who have undergone tubal ligation, any infertility services if the male has undergone a vasectomy, and all costs for and relating to surrogate motherhood (maternity services are Covered for Members acting as surrogate mothers). We also do not Cover services to reverse voluntary sterilizations.

19. Learning and behavioral disorders. Services for the evaluation or treatment (including remedial education) of: learning disabilities or minimal brain dysfunction; mental retardation; developmental and learning disorders or behavioral problems. We also do not Cover behavioral training or cognitive rehabilitation.

20. When Medicare is the primary payor, We Cover the services provided by this Certificate only to the extent they are not Covered under Medicare.

21. Mental Health Services. Please check your Summary of Benefits to see if coverage of these services has been added through a rider.

22. Military service-related conditions. Conditions that are connected with a Member's service in the military and for which the Member is legally entitled to receive services at a government facility.

23. No-fault automobile insurance. Any personal injury benefits payable under mandatory no-fault automobile insurance or for Covered Services which are eligible for payment under the provisions of an automobile insurance contract or pursuant to any federal or state law which mandates indemnification for such services to persons suffering bodily injury from motor vehicle accidents, where permitted by law.

24. Non-eligible institutions. Any services or supplies furnished by a non-eligible institution, which is defined as other than a Hospital or Skilled Nursing Facility, and which is primarily a place of rest, a place for the aged, or any similar institution, regardless of how denominated.

25. Non-medical services and long-term rehabilitation services for physical therapy or the treatment of alcoholism or drug abuse, including rehabilitation services in a specialized inpatient or residential facility, except as specifically Covered under this Certificate.

26. No-show charges. If a Provider charges a fee for a missed appointment, you will be responsible for the payment of the fee.

27. Occupational conditions, ailments, or injuries arising out of and in the course of employment. Such conditions, ailments, or injuries are not Covered if they are subject to coverage, in whole or in part, under any Workers' Compensation, occupational disease or similar law. This applies even if the Member's rights have been waived or qualified.

28. Outpatient prescription drugs.

29. Private or special duty nursing.

30. Recreational, educational or sleep therapy and related diagnostic testing.

31. Rehabilitation services or physical therapy on a long-term basis. Speech or occupational therapy to correct a condition that is not the result of a disease, an injury or a congenital defect for which surgery has been performed.

32. Routine foot care, including nail trimming, corn and callous re-moval, cleaning, soaking or any other hygienic maintenance or care.

33. Sex, marital or religious counseling, including sex therapy and treatment of sexual dysfunction.

34. Sex transformations. Any procedure or treatment designed to alter the physical characteristics of a Member from the Member's biological sex to those of the opposite sex, regardless of any diagnosis of gender role or psychosexual orientation problems.

35. Special foods and diets, supplements, vitamins and enteral feedings.

36. Special medical reports not directly related to treatment. Appearances in court or at a hearing.

37. Temporomandibular joint syndrome. Dental procedures and appliances for the treatment of temporomandibular joint syndrome or craniomandibular pain syndrome are not Covered. Surgical and non-surgical medical procedures are Covered if Precertified and approved by Our Medical Director.

38. Third-party requests for physical examinations, diagnostic services and immunizations in connection with: obtaining or continuing employment; obtaining or maintaining any license issued by a municipality, state or federal government; obtaining insurance coverage; foreign travel; school admissions or attendance, including examinations required for participation in athletic activities.

39. Transplants that are experimental, investigational or ineffective. Transplant services required by a Member when the Member serves as an organ donor are not Covered unless the recipient is a Member. The medical expenses of a non-Member acting as a donor for a Member are not Covered if the non-Member's expenses will be covered under another health plan or program. Donor fees in connection with organ transplant surgery are excluded. We do not Cover travel expenses, lodging, meals or other accommodations for donors or guests.

40. Coverage outside of the United States. Only Medical Emergencies and Urgent Care will be Covered outside of the United States (with the exception of Canada, Mexico and U.S. possessions). Additionally, We will not Cover any treatment, drugs or supplies that are unavailable or illegal in the United States.

41. Usual, Customary and Reasonable Charges (UCR). Any charges that are in excess of the UCR charges as determined by Us for Covered Services are excluded from coverage and are the Member's responsibility.

5. CLAIM REVIEW (APPEAL)

We will provide you with an explanation for actions taken on each claim that you submit to Us. If you disagree with any decision, you may appeal through the Grievance Procedure, as described in the HMO Certificate.

6. NETWORK PROVIDERS

If you receive Covered Services from a Network Provider but not in accordance with the terms and conditions of the HMO Certificate, coverage will be provided under this Certificate. When you see a Network Provider under these circumstances, the Covered Services will be treated as if they were delivered by a non-Network Provider, and you must file a claim, as described above.

Section IX.
Other Important Documents

1. SUPPLEMENTAL COVERAGE BY RIDER

The terms and conditions of this Certificate are subject to revision, addition, or deletion. Any such changes will be made by a rider. The terms of a rider that is issued by Us and accepted by the Group will supersede conflicting terms in this Certificate. Riders that are part of your Plan will be issued with your Certificate. You should check your Summary of Benefits or verify with the Group whether your Plan is subject to any rider.

Please check with your Benefits Administrator to make sure you have the most recent documents concerning your supplemental coverage under the Plan.

2. SUMMARY OF BENEFITS

In order to receive Covered Services under this Certificate, We may require that you pay a set percentage of charges (Coinsurance) to the provider who supplied the Covered Services. In addition, certain other charges, such as a Deductible, may be applied. You will receive a Summary of Benefits that will explain when Coinsurance and other similar features of your Plan will be applied. It will also inform you of any applicable benefit maximums (e.g., limits on days, visits or amounts payable).

Please check with your Benefits Administrator to make sure you have the most recent documents concerning your supplemental coverage under the Plan.

Section X.
General Administrative Policies and Procedures

1. MEDICAL RECORDS: CONFIDENTIALITY AND AUTHORIZATION TO EXAMINE

Your medical records are confidential documents. Access to those records will be limited to persons who need to see them. They will be used to determine appropriate medical care for you, to administer this Plan, and, in some cases, to meet state and federal regulatory requirements. Your records will not be released for any other reason without your consent. By participating in the Plan, you agree and authorize Us, Network Physicians, other Network Providers and non-Network Providers to permit the examination and copying of any portion of your Hospital or medical records, when requested by Us for the reasons discussed above.

If you would like a description of Our procedures for maintaining confidentiality of Member information; Please follow the instructions in "Getting Started" under "More Information About Oxford Coverage."

2. COORDINATION OF BENEFITS (COB)

A Member may be covered by two or more plans at the time that Covered Services are rendered. In determining what benefits are payable under this Certificate, We will do the following:

First:

We will provide the Covered Services required. Then, We will take into account any other coverages. These other coverages are plans that provide medical, dental or prescription drug benefits or services, including but not limited to:

A. Any group insurance, prepaid health plans, or any other insured or uninsured arrangement of group coverage.

B. Where permitted by state law, any automobile insurance contract, pursuant to any federal or state law, which mandates indemnification for medical services to persons suffering bodily injury from motor vehicle accidents, but only if:

a. Covered Services are eligible for payment under the provisions of such policy; and

b. the policy does not, under its rules, determine its benefits after the benefits of any group health insurance.

Please note: This Plan does not coordinate benefits with itself.

Second:

If there is other coverage, We will calculate the Allowable Expense. The Allowable Expense is any necessary, reasonable and customary item of expense that is at least partly covered under one or more of the plans covering the Member.

When a plan provides services instead of paying cash, the value of each service rendered will be considered to be both: an Allowable Expense and a benefit paid.

6. MEDICARE AND OTHER GOVERNMENT PROGRAMS

This Plan is not intended to duplicate any coverage for which Members are or could be eligible, such as Medicare or any other federal or state government programs. Any benefits payable under any such programs for Covered Services provided or benefits paid under this Certificate shall be payable to and retained by Us. You agree to complete and submit to Us any documentation reasonably necessary for Us to receive or ensure reimbursement under Medicare or any other government programs for which you or your Covered Dependents are eligible.

Benefits for Medicare Eligibles Who are Covered Under this Certificate

1. If your Group has 20 or more employees, any active employee or spouse of an employee who becomes or remains a member of the Group Covered by this Certificate, after becoming eligible for Medicare due to reaching age 65, will receive the benefits of this Certificate as primary, unless such Subscriber elects Medicare as his or her primary coverage. However, the Subscriber must notify Us of the election by signing and submitting to Us an election card which indicates his or her choice. He or she must also pay any required premium. Any Subscriber who elects Medicare as primary shall not be eligible for coverage under this Certificate as of the date of election.

2. If your Group has 100 or more employees or your group is an organization which includes an employer with 100 or more employees, any active employee, spouse of an active employee or Dependent child of an active employee who becomes or remains a member of the Group Covered under this Certificate, after becoming eligible for Medicare due to disability, will receive the benefits of this Certificate as primary, unless the Subscriber elects Medicare as his or her primary coverage. However, the Subscriber must notify Us of his or her election by signing an election card which indicates his or her choice. He or she must also pay any required Premium. Any Subscriber who elects Medicare as primary will not be eligible for coverage under this Certificate as of the date of this election.

Section XI.
General Provisions

1. Entire Agreement. This Certificate, the HMO Certificate, the Freedom Plan® Summary of Benefits, any Certificate riders issued to and accepted by the Group, the Group Enrollment Agreements, and the individual applications of you and your Covered Dependents, if any, constitute the entire contract between the parties and, as of the effective date hereof, supersede all other agreements between the parties. Any and all statements made to Us by the Group and any Subscriber or Covered Dependent will, in the absence of fraud, be deemed representations and not warranties, and no such statement, unless it is contained in a written application for coverage under this Certificate, shall be used in defense to a claim under this Certificate.

2. Form or Content of Certificate. No agent or employee of Us is authorized to change the form or content of this Certificate. Such changes can be made only through an endorsement authorized and signed by one of Our officers.

3. Identification Cards. Cards issued by Us to Members are for identification only. Possession of an identification card confers no right to services or other benefits, under this Certificate. To be entitled to such services or benefits the holder of the card must, in fact, be a Member on whose behalf all applicable Premiums under this Certificate and the HMO Certificate have actually been paid. Any person receiving services or other benefits to which he is not then entitled pursuant to the provisions of this Certificate will be liable for the actual cost of such services or benefits.

4. Notice. Any notice required under this Certificate may be given to Us by U.S. Mail, first class, postage prepaid, to the Customer Service address listed in the front of the Certificate. Notice to a Member will be sent to the last address We have for that Member. Member agrees to provide Us with notice, within 31 days, of any change of address.

5. Interpretation of Certificate. The laws of the State of New York shall be applied to interpretations of this Certificate.

6. Assignment. This Certificate is not assignable by Group without Our written consent. Any benefits under this Certificate are not assignable by any Member without Our written consent. In addition, This Agreement shall not confer any rights or obligations on third parties except as specifically provided herein.

7. Gender. The use of any gender in this Certificate is deemed to include the other gender, and, whenever appropriate, the use of the singular is deemed to include the plural (and vice versa).

8. Modifications. By this Certificate, the Group makes Our coverage available to Members who are eligible under the terms of the Certificate. However, this Certificate is subject to amendment, modification and termination in accordance with this provision, the Group Enrollment Agreement or by mutual agreement between Us and Group's Board of Directors, without the consent or concurrence of any Member. By enrolling in this Plan, all Members legally capable of contracting, and the legal representatives of all Members incapable of contracting, agree to all its terms, conditions, and provisions.

9. Clerical Error. Clerical error, whether by the Group or Us, with respect to this Certificate or any other documentation issued by Us in connection with this Certificate, or in keeping any record pertaining to the coverage hereunder, will not modify or invalidate coverage otherwise validly in force or continue coverage otherwise validly terminated.

10. Policies and Procedures. We may adopt reasonable policies, procedures, rules and interpretations to promote the orderly and efficient administration of this Certificate with which Members shall comply.

11. Waiver. The waiver by any party of any breach of any provision of the Agreement will not be construed as a waiver of any subsequent breach of the same or any other provision. The failure to exercise any right hereunder will not operate as a waiver of such right.

12. Termination of the Agreement. The Agreement will continue in effect for the period of time specified in the Agreement and may be canceled in accordance with the terms of the Agreement.

13. Incontestability. Except as to a fraudulent misstatement: No statement made by the Group or any Member will be the basis

Oxford Health Plans®

Oxford Health Insurance, Inc.

Mental Health and Substance Abuse Rider

Your supplemental Certificate of Coverage & Member Handbook ("Certificate") is revised as follows:

I. Coverage

1. Mental Health Services

a. Inpatient

We Cover Inpatient and Equivalent Care for the treatment of mental or nervous disorders. We define "Inpatient Care" to mean treatment provided in a hospital as defined below. "Equivalent Care" is provided in a setting, other than such hospital, that We and the Provider deem to be safe and medically appropriate.

We reserve the right to provide this benefit in the modality We determine to be both medically appropriate and the most cost effective.

Inpatient and Equivalent Care mental health services are Covered only when obtained from facilities licensed by the appropriate state regulatory authority as well as any other Provider We deem appropriate to provide the Medically Necessary level of care. Alcoholism and substance abuse related rehabilitation are not considered mental health services under this provision.

For Inpatient and Equivalent care, We cover up to the amount of days shown in your Summary of Benefits.

b. Outpatient

We cover outpatient visits for the treatment of mental or nervous disorders. A "visit" for the purposes of this provision is 45 to 60 minutes of therapy.

Outpatient mental health services are Covered only when obtained from duly licensed: psychiatrists or practicing psychologists; or by certified social workers or mental hygiene facilities. Alcoholism and substance abuse related rehabilitation are not considered mental health services under this provision.

We Cover up to the amount of visits shown in your Summary of Benefits.

Alcoholism and Substance Abuse

a. Detoxification

Inpatient detoxification is Covered up to the amount of days and admissions shown in your Summary of Benefits.

b. Inpatient Services

Treatment in a Plan Specialized Rehabilitation Facility will be Covered, in accordance with an individual treatment plan prepared by your Provider. Coverage is limited to the amount of days shown in your Summary of Benefits.

II. Precertification

All treatment received under this Rider must be precertified and described in Section I. Of your Certificate.

III. Coinsurance and Benefit Limitations

All covered Services under this Rider are subject to UCR, Deductible and the Coinsurance shown in your Summary of Benefits.

IV. Miscellaneous Provisions

All benefits are on a per Member, per calendar year basis.

The "Exclusions and Limitations," section of your Certificate is amended as follows:

a. The exclusion regarding inpatient alcohol and substance abuse treatment and detoxification is removed from the Certificate.

b. The exclusion regarding mental health services is removed from the Certificate.

This Rider supersedes any amendment or rider providing coverage for Mental Health and Substance Abuse previously issued by Us. In the event of a conflict between the provisions of this Rider and the Certificate, the provisions of this Rider will prevail. All other terms and conditions of the Certificate remain in full force and effect.

Nothing contained in this Rider will be held to vary, alter, waive, or extend any of the terms, conditions, provisions or limitations of the Agreement to which this Rider is attached, other than as specifically stated herein.

Exhibit G

Pursuant to Rule 5 of the United States District Court for the Southern District of New York Procedures For Electronic Case Filing only excerpts of the referenced document have been electronically filed due to the volume of the exhibit.

(This exhibit has been Bates Stamped and a complete copy is being served on plaintiff.).

This filing is without prejudice to any parties' right to supplement the exhibit or file the complete document.

4/1/04

REDACTED

EC1227_CSP01

1050 FIFTH AVENUE

NEW YORK, NY 10028

Your Oxford Coverage for all seasons

OXFORD HEALTH PLANS®

A UnitedHealthcare Company

REDACTED

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1050 FIFTH AVENUE

NEW YORK, NY 10028

FREEDOM PLAN®

OXFORD HEALTH PLANS®

A UnitedHealthcare Company

14 Feb 2008
2184 (07/05)

[redacted]

2004 CERT 002

Oxford Health Plans®

Dear Oxford Member,

Welcome, and thank you for selecting Oxford Health Plans.

Oxford wants to play an active role in your life and health by bringing quality, choice, and service to a higher level. We call this being a healthcare catalyst—where our access to a quality network, preventive programs, and practical resources are all working together to help you move to a healthier place. As an Oxford Member you have access to:

- A comprehensive network of doctors and hospitals
- Healthcare guidance 24 hours a day, seven days a week, from Oxford's registered nurses through *Oxford On Call®*
- *www.oxfordhealth.com,* Oxford's award-winning web site, which allows you to conduct transactions (e.g., request an ID card, change your primary care physician) and access health information quickly and easily
- A credentialed network of 2, 400 complementary and alternative medicine providers in Connecticut, New York, and New Jersey—including acupuncturists, chiropractors, nutritionists, message therapists, etc.
- Healthy Mind Healthy Body® magazine, your source for health information on prevention, nutrition, and exercise, as well as important benefit and coverage information

Enclosed is your new Summary of Benefits, Certificate of Coverage, and other important plan information. If you have questions about your coverage, please log in to *www.oxfordhealth.com* or call Customer Service at the number on your Oxford ID card.

To learn more about Oxford's programs that can help you achieve your best state of health, visit our web site at *www.oxfordhealth.com.*

Wishing you the best of health.

Sincerely,

Chuck Berg
Chief Executive Officer

Enclosures

MS-02-1596 CT NY NJ 1/03

[redacted]

2004 CERT 003

OXFORD HEALTH PLANS (NY), INC.

FREEDOM PLAN

SUMMARY OF BENEFITS

Entwistle & Cappucci LLP

PLEASE REVIEW MAXIMUMS AND LIMITATIONS (PAGES 7 & 8)

COVERED SERVICES	*IN-NETWORK	**OUT-OF-NETWORK
Primary and Preventive Care		
	Physician Office and Home Visits	Preventive care is available only to Members age 19 and under and is subject to Deductible and 20% Coinsurance.
	No Charge for Preventive Care visits	
	$10 copay per visit for treatment of illness or injury	Office or home visits for treatment of illness or injury are Covered subject to Deductible and 20% Coinsurance.
		Some procedures require Precertification. Please see your Certificate.
	Two well-woman examinations, two Pap tests and age appropriate mammograms per Calendar Year are Covered No Charge.	Female Members may receive annual Pap tests and age appropriate mammogram subject to Coinsurance and Deductible. Well-woman examinations are not Covered.
Inpatient Hospital Visits	No Charge	Covered subject to Deductible and 20% Coinsurance.
Diabetes Education and Self-Management	$10 copay per visit.	Covered subject to Deductible and 20% Coinsurance.

*The In-Network benefits are provided through your HMO Certificate of Coverage and Member Handbook issued to you by Oxford Health Plans (NY), Inc. In order for a Covered Service to be Covered In-Network, the service must be obtained in accordance with terms and conditions of the HMO Certificate.

All Covered Services must be provided or arranged by the Member's PCP or Network Provider of OB/GYN care.

**The Out-of-Network benefits are provided through your Supplemental Certificate of Coverage and Member Handbook issued to you by Oxford Health Insurance, Inc. Covered Services are reimbursed only in accordance with its terms and conditions.

COVERED SERVICES	*IN-NETWORK	**OUT-OF-NETWORK
Primary and Preventive Care (cont.)		
Diabetic Supplies	$10 per 30-day supply of each item	Covered subject to Deductible and 20% Coinsurance. **Precertification is required before the purchase of an insulin pump.**
Specialty Care		
Physician Office and Home Visits	$10 copay per visit.	Covered subject to Deductible and 20% Coinsurance. **Some procedures require Precertification.** **Please see your Certificate.**
Inpatient Hospital Visits	No Charge.	Covered subject to Deductible and 20% Coinsurance.
Obstetrical Services (including prenatal and postnatal)	$10 copay per initial visit.	Covered subject to Deductible and 20% Coinsurance. **Precertification is required.**
Elective Termination of Pregnancy	No Charge.	Covered subject to Deductible and 20% Coinsurance.
Basic & Comprehensive Infertility Services		
Outpatient	No Charge. **Advanced Services are Not Covered.**	Covered subject to Deductible and 20% Coinsurance. **Precertification is required.** **Advanced Services are Not Covered.**
Inpatient	No Charge **Advanced Services are Not Covered.**	Covered subject to Deductible and 20% Coinsurance. **Precertification is required.** **Advanced Services are Not Covered.**
Office Visits	$10 copay per office visit. **Advanced Services are Not Covered.**	Covered subject to Deductible and 20% Coinsurance. **Advanced Services are Not Covered.**

COVERED SERVICES	*IN-NETWORK	**OUT-OF-NETWORK
Specialty Care (cont.)		
Allergy Testing and Treatment	$10 copay per visit.	Covered subject to Deductible and 20% Coinsurance.
Short-Term Rehabilitative Services (Physical, Speech and Occupational)		
Outpatient	$10 copay per visit.	Covered subject to Deductible and 20% Coinsurance.
Rehabilitation Services Inpatient	No Charge	Covered subject to Deductible and 20% Coinsurance. **Precertification is required.**
Oral Surgery	No Charge	Covered subject to Deductible and 20% Coinsurance. **Precertification is required.**
Pediatric Preventive Dental (through age 11)	No Charge.	No Charge
Laboratory Procedures and X-ray Examinations	No Charge.	Covered subject to Deductible and 20% Coinsurance. **Precertification is required for PET Scans, MRAs and surgical endoscopic procedures MRIs, Bone Density Studies, Nuclear Medicine and CAT Scans.**
Diagnostic Mammography	No Charge.	Covered subject to Deductible and 20% Coinsurance.
Prosthetic Devices	No Charge for an internal prosthetic device.	Internal prosthetic devices are Covered subject to Deductible and 20% Coinsurance.
		Surgery is Covered subject to Deductible and 20% Coinsurance.
	External devices have no Copayment.	External Devices are Covered subject to Deductible and 20% Coinsurance. **Precertification is required before purchase.**

COVERED SERVICES	*IN-NETWORK	**OUT-OF-NETWORK
Specialty Care (cont.)		
Durable Medical Equipment	No Charge	Covered subject to Deductible and 20% Coinsurance. **Precertification is required on items that cost $500 or more.**
Medical Supplies	**No In-Network Benefit**	Covered subject to Deductible and 20% Coinsurance.
Transplants	Transplants performed at Our approved facilities are covered at No Charge. Transplants are performed at other Network facilities are covered on an Out-of-Network basis.	Covered subject to Deductible and 20% Coinsurance. **Precertification is required.**
Home Health Services	$10 copay per visit.	Covered subject to 20% Coinsurance. Not subject to Deductible. **Precertification is required.**
Chiropractic Services	$10 copay per visit.	Covered subject to Deductible and 20% Coinsurance.
Second Opinions	At your request $10 copay per visit. At Our request, No Charge.	Covered subject to Deductible and 20% Coinsurance.
Hospital and Other Facility Based Services		
Inpatient Hospital Services	No Charge	Covered subject to Deductible and 20% Coinsurance. **Precertification is required.**
Outpatient Hospital Services and Ambulatory Surgical Center Services	No Charge	Covered subject to Deductible and 20% Coinsurance. **Precertification is required.**
Skilled Nursing Facility Services	No Charge	Covered subject to Deductible and 20% Coinsurance. **Precertification is required.**

COVERED SERVICES	*IN-NETWORK	**OUT-OF-NETWORK
Hospital and Other Facility Based Services (cont.)		
Hospice Services		
Inpatient	No Charge	Covered subject to Deductible and 20% Coinsurance. **Precertification is required.**
Outpatient	No Charge	Covered subject to Deductible and 20% Coinsurance. **Precertification is required.**
Home Health Service	$10 copay per visit.	Covered subject to 20% Coinsurance. Not subject to Deductible. **Precertification is required.**
Skilled Nursing Facility Services	No Charge	Covered subject to Deductible and 20% Coinsurance. **Precertification is required.**
Alcohol and Substance Abuse Services		
Outpatient Alcohol and Substance Abuse Rehabilitation	No Charge	Covered subject to Deductible and 20% Coinsurance. **Precertification is required.**
Medical Emergency and Urgent Care Services		
Emergency Room Services	$50 per visit (Waived if a Member becomes confined in a hospital)	When proper notice is **not** given, Medical Emergency Admissions are Covered as described in the Supplemental Certificate subject to Deductible and 50% Coinsurance.
Urgent Care Facility Services	When proper notice is given, the services of Network and Non-Network Providers are Covered at $10 copay per visit.	Covered subject to Deductible and 20% Coinsurance.
Ambulance Services	No Charge	All Covered Ambulance Services will be Covered as an In-Network benefit.

COVERED SERVICES	IN-NETWORK	*OUT-OF-NETWORK
Supplemental Riders		
Outpatient Prescription Drugs:		
	$7 per 30-day supply of each Generic Prescription and refill. $20 per 30-day supply of each Preferred Brand Prescription and refill. $40 per 30-day supply of each Non-Preferred Brand Name Prescription and refill. Mail Order Drugs: 2 Copayments for a 90-day supply.	
Inpatient Mental Health Services	No Charge	Not Covered
Outpatient Mental Health Services	Covered subject to a Copayment of 50% of the cost of each visit.	Covered subject to Deductible and 50% Coinsurance. We pay a maximum benefit of $25 per visit. **Precertification is required.**
Inpatient Substance Abuse Rehabilitation and Detoxification	No Charge	Not Covered

COVERED SERVICES	IN-NETWORK	OUT-OF-NETWORK

Supplemental Riders (cont.)

Important: Coverage under the Supplemental Certificate does not duplicate coverage under the HMO Certificate. Benefits are not cumulative. Benefits received under the Supplemental Certificate reduce the amount of benefits available under the HMO Certificate and Benefits received under the HMO Certificate reduce the amount of benefits available under the Supplemental Certificate.

MAXIMUMS AND LIMITATIONS

Unless otherwise indicated, the following maximums and limitations apply to both the In-Network and Out-of-Network Benefits combined.

All reimbursements for Out-of Network benefits are subject to UCR at the 90th percentile of HIAA.

Diabetic Supplies	Diabetic supplies will only be supplied in amounts consistent with the Member's treatment plan as developed by the Member's Physician. Only basic models of Blood glucose monitors are Covered unless the Member has special needs relating to poor vision or blindness.
Elective Termination of Pregnancy	We Cover one procedure per Member per Calendar Year. We pay a maximum benefit of $350 per procedure.
Short-Term Rehabilitation Therapy Services (Physical, Speech, Occupational)	
Inpatient	One consecutive 60-day period per condition, per lifetime.
Outpatient	90 visits per condition, per lifetime.
Durable Medical Equipment	We will pay a maximum benefit of $1,500 per Member, per Calendar Year.

MAXIMUMS AND LIMITATIONS (cont.)

Transplants	In-Network Coverage is available only at Network facilities specifically approved and designated by Us to perform these procedures.
Home Health Services	60 visits per Calendar Year
Exercise Facility Reimbursement	Within one 6-month period We will reimburse you $200. We will reimburse your spouse $100 per 6-month period. The Member must complete 50 visits within the 6-month period.
Skilled Nursing Facility Services	30 days per Calendar Year
Hospice Services	210 days
Bereavement Counseling for Member's Family	5 sessions either before or after the death of the Member
Outpatient Alcoholism and Substance Abuse Rehabilitation	60 visits per Calendar Year. Up to 20 of these visits may be used by the Member's family.
Supplemental Rider Information	
Inpatient Mental Health Services	30 days per Calendar Year
Outpatient Mental Health Services	30 visits per Calendar Year
Inpatient Alcoholism and Substance Abuse Rehabilitation	30 days per Calendar Year
Detoxification	7 days per Calendar Year
Exercise Facility Reimbursement	Within one 6-month period We will reimburse you $200. We will reimburse your spouse $100 per 6-month period. The Member must complete 50 visits within the 6-month period.

FAILURE TO PRECERTIFY

If you fail to obtain a required Precertification for an Out-of-Network benefit, you will be subject to a reduction in benefits. You must pay Deductible and 50% of the costs for such service or supply.

DEDUCTIBLES

The applicable Deductibles for this Plan are:

Out-of-Network	Individual: $250
	Family: $625

OUT-OF-POCKET MAXIMUM

The maximum amount you must pay in any Calendar Year for Out-of-Network Covered Services is $1,250 for an individual and $3,125 per family.

Remember, only Coinsurance and the amounts paid to meet your Deductible count toward the Out-of-Pocket Maximum. Copayments for In-Network benefits, amounts in excess of the UCR, amounts paid for non-Covered Services, and any amounts paid as a penalty do not count toward the Out-of-Pocket Maximum.

Coinsurance paid for any Covered Service obtained under a Supplemental Coverage (excluding State mandated offers) will not be applied toward the Out-of-Pocket Maximums. Therefore, amounts paid for: outpatient prescription drugs will not be applied toward the Out-of-Pocket Maximum.

ELIGIBILITY LIMITS

The limiting ages for dependents (as defined in the HMO Certificate) are: under the age of 19 and between the ages of 19 and 23 for a full-time student. Coverage ends at the end of the Calendar Year.

EFFECTIVE DATES OF COVERAGE

Initial Enrollment (During the initial Group Open Enrollment Period.) Coverage is effective on the effective date of the Agreement.

Newly Eligible Employee (Application within 31 days of becoming eligible.) Coverage is effective as of the date the employee became eligible.

Newly Eligible Dependents(Application within 31 days of becoming eligible). Coverage is effective as of the date the dependent became eligible. Coverage is effective at birth for newborns and newly born adopted children subject to enrollment requirements as described in the Certificate.

Group Open Enrollment Period. Coverage will be effective on the renewal date of the Agreement.

IMPORTANT: This document is not a contract. It is only a summary of your coverage under the FREEDOM PLAN. Please read your HMO Certificate and your Supplemental Certificate for a full description of your Covered Services, exclusions and other terms and conditions of coverage.

Oxford Health Plans

IMPORTANT

This booklet contains your Certificates of Coverage and explains your new healthcare coverage. As a Member of the Oxford Freedom Plan®, each time you see a doctor you have the choice of seeking care on an In-Network basis through your Oxford primary care physician or on an Out-of-Network basis. In order to thoroughly explain your coverage, We provide you with TWO DIFFERENT CERTIFICATES, one for In-Network and one for Out-of-Network benefits.

In-Network Coverage

If you receive care from your Oxford Primary Care Physician or from an Oxford Network Specialist with an authorized referral, you are eligible for "In-Network" coverage. Your In-Network benefits and coverage are explained in the first half of your handbook. This part of your handbook has its own Table of Contents and "Getting Started" guide to your In-Network benefits.

Out-of-Network Coverage

If you receive Covered Services from a physician other than your Oxford Primary Care Physician, or from an Oxford Network Specialist without an authorized referral, you are eligible for "Out-of-Network" coverage. Out-of-Network benefits and coverage are explained in the second half of your handbook. This Supplemental Certificate of Coverage restarts with its own Table of Contents and another "Getting Started" guide to your benefits.

Each time you see a doctor, remember to look in the appropriate section of your handbook to determine your exact benefits. If you have any questions or need assistance, Our Customer Service Associates will be happy to help you. They are available at 800-444-6222, Monday through Friday, 8 AM to 6 PM, or after hours at 800-899-9039.

Oxford Health Plans®

OXFORD HEALTH PLANS (NY), INC

Supplemental Certificate of Coverage
&
Member Handbook

This Certificate describes your Out-of-Network coverage under the Freedom Plan®

SUPPLEMENTAL CERTIFICATE OF COVERAGE ("Certificate")
for
Oxford Health Insurance, Inc. ("Oxford")

Please read this entire Certificate carefully, including your Summary of Benefits, which contains information specific to your Group. These documents, and any attached riders, describe your rights and obligations and those of Oxford.

Under this Certificate, you engage Oxford to pay benefits for Covered medical and Hospital services in accordance with the terms and conditions of this Certificate and in reliance upon the statements you made in your application for coverage.

Oxford agrees with the Group to administer the Covered Services set forth in this Certificate, as may be amended from time to time by Oxford or the Group's Board of Directors. Please note:

- This Certificate and any riders, schedules or attachments have been delivered in consideration of the Group's timely payment of Premiums.
- No services are Covered under this Certificate in the absence of current payment of Premiums, subject to a 30-day Grace Period and the terms and conditions of the Certificate.
- No services are Covered under this Certificate unless coverage was in force at the time the service was obtained.
- In some instances, a medical procedure may not be Covered or may require Precertification. It is your responsibility to understand the terms and conditions in this Certificate.
- This Certificate cancels and replaces any prior Certificate issued to you by Oxford Health Insurance, Inc., for coverage under the Freedom Plan®.
- This Certificate is not in lieu of and does not affect any requirements for coverage by Workers' Compensation Insurance.
- This Certificate does not constitute the entire Agreement between Oxford Health Insurance, Inc., and the Group. While this Certificate has been made a part of the Group Enrollment Agreement, certain terms and conditions may only be described in the Group Enrollment Agreement itself. If questions arise, the terms of the Group Enrollment Agreement will govern. A copy of the Group Enrollment Agreement is available, upon request, from your employer.

This Certificate is governed by the laws of the State of New York.

check your HMO Certificate to determine what coverage is available.

Section IV. Exclusions and Limitations

Unless coverage is specifically provided under this Certificate or provided under a rider or attachment to this Certificate, the following services and benefits are **not Covered.**

1. Services which are not Medically Necessary. If there is a dispute between a provider and **Us** about the Medical Necessity of a service or supply, you may appeal **Our** decision. Any disputed service or supply will not be Covered during the appeal process (please refer to the "Utilization Review Appeal" provision of the HMO Certificate).

2. A portion of the cost of services for which a required Precertification was not obtained.

3. Acupuncture therapy.

4. Adopted newly born infant's initial hospital stay if either of the natural parents has coverage available for the infant's care.

5. Alcohol and substance abuse treatment on an inpatient basis. Detoxification is not Covered.

6. Blood, blood plasma and blood derivatives other than those described as Covered under Section III of this Certificate. Synthetic blood, apheresis or plasmapheresis, the collection and storage of blood or the cost of securing the services of blood donors are not Covered.

7. Birth control pills, implantable contraceptive drugs, condoms, foams or devices, IUDs, diaphragms, contraceptive jellies and ointments, even if they are being prescribed or recommended for a medical condition other than birth control.

8. Care for conditions that by federal, state or local law must be treated in a public facility, including, but not limited to, commitments for mental illness. Additionally, to the extent allowed by law, we do not Cover care or treatment provided in a Hospital that is owned or operated by any federal, state or other governmental entity.

9. Comfort or convenience items, including but not limited to: barber services; guest meals and accommodations; telephone, television or radio charges; travel expenses; or take-home supplies. We also do not Cover the purchase or rental of household fixtures or equipment, including but not limited to: escalators; elevators; swimming pools; exercise cycles; air purifiers; air conditioners; water purifiers; allergenic pillows, mattresses or waterbeds.

10. Cosmetic, plastic or reconstructive surgery which is performed primarily to improve the appearance of any portion of the body, including but not limited to: surgery for sagging of extra skin; any augmentation or reduction procedure (e.g., mammoplasty); liposuction; keloids; rhinoplasty and associated surgery. Complications of such surgery are Covered only if they are Medically Necessary and are otherwise Covered. Remedial surgery is not Covered.

11. Court-ordered services or services that have been ordered as a condition of probation or parole. However, these services may be Covered if We agree that the services are Medically Necessary, the Member has not exhausted his or her benefit for the calendar year, and the treatment is provided in accordance with Our policies and procedures.

12. Custodial care, domiciliary care, long-term care, maintenance care, adult day care or rest cures. We do not Cover room, board, nursing care or personal care which is rendered to assist a Member who, in Our opinion, has reached the maximum level of physical or mental function realistically possible and will not make further significant clinical improvement.

13. Dental services related to the care, filling, removal or replacement of teeth and the treatment of injuries or diseases of the teeth, gums and temporomandibular joint, including but not limited to: apicoectomy, orthodontics, root canals, soft tissue impaction, temporomandibular joint dysfunction therapy, alveolectomy, treatment of periodontal disease or orthognathic surgery. As described in Section III, 2, G, "Oral Surgery," only dental services required to treat accidental injury of sound, natural teeth are Covered.

14. Diabetes; limitations and exclusions. The Covered Services specified in this Certificate are Covered only as follows:

a. The items are Medically Necessary, as determined by **Us**, and are provided in amounts that are in accordance with a reasonable treatment plan developed by a Physician for the Member.

b. All requests for insulin pumps must first be reviewed by one of Our Medical Case Managers and approved by Our Medical Director.

c. Only basic models of blood glucose monitors will be covered, unless the Member has special needs relating to poor vision or blindness.

The following are not Covered:

a. Membership in health clubs, diet plans, or other organizations, even if recommended by a Physician or a Qualified Health Provider for the purpose of losing weight.

b. Any counseling or courses in diabetes management other than as described in this Certificate. Stays at special facilities or spas for the purpose of diabetes education/management.

c. Special foods, diet aids and supplements related to dieting.

d. Any item that is not both Medically Necessary and prescribed by the Member's Physician or Qualified Health Provider.

15. Durable Medical Equipment: We do not Cover: orthotics, arch supports, corrective shoes, false teeth, hearing aids.

16. Experimental, investigational or ineffective surgical or medical treatments, procedures, drugs, or research studies, including but not limited to: transplants, stem cell retrieval, cancer chemotherapy protocols, AIDS clinical trials or I.V. therapies that are not recognized as acceptable medical practice, and any such services where federal or other governmental agency approval is required but has not been granted. We will make the determination as to whether the requested service is excluded in accordance with this provision. In certain instances, such procedures may be Covered if they are approved in advance by Our Medical Advisory Board and provided in accordance with the provisions of this Certificate.

17. Emergency Care. Emergency Care is Covered only to the extent described in Section III, 5, "Medical Emergencies and Urgent Care," in this Certificate. Also excluded is improper use of an emergency room or emergency admissions. Routine care and treatment for conditions that We determine were not Medical Emergencies, when received in an emergency room, are not Covered.

18. Infertility treatment and supplies (except as otherwise Covered under this Certificate), even if the treatment or supply is for a purpose other than the correction of infertility. Services and supplies that are not Covered include but are not limited to: injectable infertility drugs such as Pergonal, Metrodin, etc., cost for an ovum donor or donor sperm, sperm storage costs, cryopreservation and storage of embryos, ovulation predictor kits, in-vitro services for women who have undergone tubal ligation, any infertility services if the male has undergone a vasectomy, and all costs for and relating to surrogate motherhood (maternity services are Covered for Members acting as surrogate mothers). We also do not Cover services to reverse voluntary sterilizations.

19. Learning and behavioral disorders. Services for the evaluation or treatment (including remedial education) of: learning disabilities or minimal brain dysfunction; mental retardation; developmental and learning disorders or behavioral problems. We also do not Cover behavioral training or cognitive rehabilitation.

20. When Medicare is the primary payor, We Cover the services provided by this Certificate only to the extent they are not Covered under Medicare.

21. Mental Health Services. Please check your Summary of Benefits to see if coverage of these services has been added through a rider.

22. Military service-related conditions. Conditions that are connected with a Member's service in the military and for which the Member is legally entitled to receive services at a government facility.

23. No-fault automobile insurance. Any personal injury benefits payable under mandatory no-fault automobile insurance or for Covered Services which are eligible for payment under the provisions of an automobile insurance contract or pursuant to any federal or state law which mandates indemnification for such services to persons suffering bodily injury from motor vehicle accidents, where permitted by law.

24. Non-eligible institutions. Any services or supplies furnished by a non-eligible institution, which is defined as other than a Hospital or Skilled Nursing Facility, and which is primarily a place of rest, a place for the aged, or any similar institution, regardless of how denominated.

25. Non-medical services and long-term rehabilitation services for physical therapy or the treatment of alcoholism or drug abuse, including rehabilitation services in a specialized inpatient or residential facility, except as specifically Covered under this Certificate.

26. No-show charges. If a Provider charges a fee for a missed appointment, you will be responsible for the payment of the fee.

27. Occupational conditions, ailments, or injuries arising out of and in the course of employment. Such conditions, ailments, or injuries are not Covered if they are subject to coverage, in whole or in part, under any Workers' Compensation, occupational disease or similar law. This applies even if the Member's rights have been waived or qualified.

28. Outpatient prescription drugs.

29. Private or special duty nursing.

30. Recreational, educational or sleep therapy and related diagnostic testing.

31. Rehabilitation services or physical therapy on a long-term basis. Speech or occupational therapy to correct a condition that is not the result of a disease, an injury or a congenital defect for which surgery has been performed.

32. Routine foot care, including nail trimming, corn and callous removal, cleaning, soaking or any other hygienic maintenance or care.

33. Sex, marital or religious counseling, including sex therapy and treatment of sexual dysfunction.

34. Sex transformations. Any procedure or treatment designed to alter the physical characteristics of a Member from the Member's biological sex to those of the opposite sex, regardless of any diagnosis of gender role or psychosexual orientation problems.

35. Special foods and diets, supplements, vitamins and enteral feedings.

36. Special medical reports not directly related to treatment. Appearances in court or at a hearing.

37. Temporomandibular joint syndrome. Dental procedures and appliances for the treatment of temporomandibular joint syndrome or craniomandibular pain syndrome are not Covered. Surgical and non-surgical medical procedures are Covered if Precertified and approved by Our Medical Director.

38. Third-party requests for physical examinations, diagnostic services and immunizations in connection with: obtaining or continuing employment; obtaining or maintaining any license issued by a municipality, state or federal government; obtaining insurance coverage; foreign travel; school admissions or attendance, including examinations required for participation in athletic activities.

39. Transplants that are experimental, investigational or ineffective. Transplant services required by a Member when the Member serves as an organ donor are not Covered unless the recipient is a Member. The medical expenses of a non-Member acting as a donor for a Member are not Covered if the non-Member's expenses will be covered under another health plan or program. Donor fees in connection with organ transplant surgery are excluded. We do not Cover travel expenses, lodging, meals or other accommodations for donors or guests.

40. Coverage outside of the United States. Only Medical Emergencies and Urgent Care will be Covered outside of the United States (with the exception of Canada, Mexico and U.S. possessions). Additionally, We will not Cover any treatment, drugs or supplies that are unavailable or illegal in the United States.

41. Usual, Customary and Reasonable Charges (UCR). Any charges that are in excess of the UCR charges as determined by Us for Covered Services are excluded from coverage and are the Member's responsibility.

Inquire about the status of a claim, call the "Claims" telephone number listed in the front of this Certificate. Please have the date of service and your ID number ready.

5. CLAIM REVIEW (APPEAL)

We will provide you with an explanation for actions taken on each claim that you submit to Us. If you disagree with any decision, you may appeal through the Grievance Procedure, as described in the HMO Certificate.

6. NETWORK PROVIDERS

If you receive Covered Services from a Network Provider but not in accordance with the terms and conditions of the HMO Certificate, coverage will be provided under this Certificate. When you see a Network Provider under these circumstances, the Covered Services will be treated as if they were delivered by a non-Network Provider, and you must file a claim, as described above.

Section IX.
Other Important Documents

1. SUPPLEMENTAL COVERAGE BY RIDER

The terms and conditions of this Certificate are subject to revision, addition, or deletion. Any such changes will be made by a rider. The terms of a rider that is issued by Us and accepted by the Group will supersede conflicting terms in this Certificate. Riders that are part of your Plan will be issued with your Certificate. You should check your Summary of Benefits or verify with the Group whether your Plan is subject to any rider.

Please check with your Benefits Administrator to make sure you have the most recent documents concerning your supplemental coverage under the Plan.

2. SUMMARY OF BENEFITS

In order to receive Covered Services under this Certificate, We may require that you pay a set percentage of charges (Coinsurance) to the provider who supplied the Covered Services. In addition, certain other charges, such as a Deductible, may be applied. You will receive a Summary of Benefits that will explain when Coinsurance and other similar features of your Plan will be applied. It will also inform you of any applicable benefit maximums (e.g., limits on days, visits or amounts payable).

Please check with your Benefits Administrator to make sure you have the most recent documents concerning your supplemental coverage under the Plan.

Section X.
General Administrative Policies and Procedures

1. MEDICAL RECORDS: CONFIDENTIALITY AND AUTHORIZATION TO EXAMINE

Your medical records are confidential documents. Access to those records will be limited to persons who need to see them. They will be used to determine appropriate medical care for you, to administer this Plan, and, in some cases, to meet state and federal regulatory requirements. Your records will not be released for any other reason without your consent. By participating in the Plan, you agree and authorize Us, Network Physicians, other Network Providers and non-Network Providers to permit the examination and copying of any portion of your Hospital or medical records, when requested by Us for the reasons discussed above.

If you would like a description of Our procedures for maintaining confidentiality of Member information, Please follow the instructions in "Getting Started" under "More Information About Oxford Coverage."

2. COORDINATION OF BENEFITS (COB)

A Member may be covered by two or more plans at the time that Covered Services are rendered. In determining what benefits are payable under this Certificate, We will do the following:

First:

We will provide the Covered Services required. Then, We will take into account any other coverages. These other coverages are plans that provide medical, dental or prescription drug benefits or services, including but not limited to:

A. Any group insurance, prepaid health plans, or any other insured or uninsured arrangement of group coverage.

B. Where permitted by state law, any automobile insurance contract, pursuant to any federal or state law, which mandates indemnification for medical services to persons suffering bodily injury from motor vehicle accidents, but only if:

a. Covered Services are eligible for payment under the provisions of such policy; and

b. the policy does not, under its rules, determine its benefits after the benefits of any group health insurance.

Please note: This Plan does not coordinate benefits with itself.

Second:

If there is other coverage, We will calculate the Allowable Expense. The Allowable Expense is any necessary, reasonable and customary item of expense that is at least partly covered under one or more of the plans covering the Member.

6. MEDICARE AND OTHER GOVERNMENT PROGRAMS

This Plan is not intended to duplicate any coverage for which Members are or could be eligible, such as Medicare or any other federal or state government programs. Any benefits payable under any such programs for Covered Services provided or benefits paid under this Certificate shall be payable to and retained by Us. You agree to complete and submit to Us any documentation reasonably necessary for Us to receive or ensure reimbursement under Medicare or any other government programs for which you or your Covered Dependents are eligible.

Benefits for Medicare Eligibles Who are Covered Under this Certificate

1. If your Group has 20 or more employees, any active employee or spouse of an employee who becomes or remains a member of the Group Covered by this Certificate, after becoming eligible for Medicare due to reaching age 65, will receive the benefits of this Certificate as primary, unless such Subscriber elects Medicare as his or her primary coverage. However, the Subscriber must notify Us of the election by signing and submitting to Us an election card which indicates his or her choice. He or she must also pay any required premium. Any Subscriber who elects Medicare as primary shall not be eligible for coverage under this Certificate as of the date of election.

2. If your Group has 100 or more employees or your group is an organization which includes an employer with 100 or more employees, any active employee, spouse of an active employee or Dependent child of an active employee who becomes or remains a member of the Group Covered under this Certificate, after becoming eligible for Medicare due to disability, will receive the benefits of this Certificate as primary, unless the Subscriber elects Medicare as his or her primary coverage. However, the Subscriber must notify Us of his or her election by signing an election card which indicates his or her choice. He or she must also pay any required Premium. Any Subscriber who elects Medicare as primary will not be eligible for coverage under this Certificate as of the date of this election.

Section XI.
General Provisions

1. Entire Agreement. This Certificate, the HMO Certificate, the Freedom Plan® Summary of Benefits, any Certificate riders issued to and accepted by the Group, the Group Enrollment Agreements, and the individual applications of you and your Covered Dependents, if any, constitute the entire contract between the parties and, as of the effective date hereof, supersede all other agreements between the parties. Any and all statements made to Us by the Group and any Subscriber or Covered Dependent will, in the absence of fraud, be deemed representations and not warranties, and no such statement, unless it is contained in a written application for coverage under this Certificate, shall be used in defense to a claim under this Certificate.

2. Form or Content of Certificate. No agent or employee of Us is authorized to change the form or content of this Certificate. Such changes can be made only through an endorsement authorized and signed by one of Our officers.

3. Identification Cards. Cards issued by Us to Members are for identification only. Possession of an identification card confers no right to services or other benefits, under this Certificate. To be entitled to such services or benefits the holder of the card must, in fact, be a Member on whose behalf all applicable Premiums under this Certificate and the HMO Certificate have actually been paid. Any person receiving services or other benefits to which he is not then entitled pursuant to the provisions of this Certificate will be liable for the actual cost of such services or benefits.

4. Notice. Any notice required under this Certificate may be given to Us by U.S. Mail, first class, postage prepaid, to the Customer Service address listed in the front of the Certificate. Notice to a Member will be sent to the last address We have for that Member. Member agrees to provide Us with notice, within 31 days, of any change of address.

5. Interpretation of Certificate. The laws of the State of New York shall be applied to interpretations of this Certificate.

6. Assignment. This Certificate is not assignable by Group without Our written consent. Any benefits under this Certificate are not assignable by any Member without Our written consent. In addition, This Agreement shall not confer any rights or obligations on third parties except as specifically provided herein.

7. Gender. The use of any gender in this Certificate is deemed to include the other gender, and, whenever appropriate, the use of the singular is deemed to include the plural (and vice versa).

8. Modifications. By this Certificate, the Group makes Our coverage available to Members who are eligible under the terms of the Certificate. However, this Certificate is subject to amendment, modification and termination in accordance with this provision, the Group Enrollment Agreement or by mutual agreement between Us and Group's Board of Directors, without the consent or concurrence of any Member. By enrolling in this Plan, all Members legally capable of contracting, and the legal representatives of all Members incapable of contracting, agree to all its terms, conditions, and provisions.

9. Clerical Error. Clerical error, whether by the Group or Us, with respect to this Certificate or any other documentation issued by Us in connection with this Certificate, or in keeping any record pertaining to the coverage hereunder, will not modify or invalidate coverage otherwise validly in force or continue coverage otherwise validly terminated.

10. Policies and Procedures. We may adopt reasonable policies, procedures, rules and interpretations to promote the orderly and efficient administration of this Certificate with which Members shall comply.

11. Waiver. The waiver by any party of any breach of any provision of the Agreement will not be construed as a waiver of any subsequent breach of the same or any other provision. The failure to exercise any right hereunder will not operate as a waiver of such right.

12. Termination of the Agreement. The Agreement will continue in effect for the period of time specified in the Agreement and may be canceled in accordance with the terms of the Agreement.

13. Incontestability. Except as to a fraudulent misstatement: No statement made by the Group or any Member will be the basis

Oxford Health Plans®

Oxford Health Insurance, Inc.

Mental Health and Substance Abuse Rider

Your Certificate of Coverage & Member Handbook ("Certificate") is revised as follows:

I. Out-of-Network Coverage

Mental Health Services

Outpatient

We cover outpatient visits for the treatment of mental or nervous disorders. A "visit" for the purposes of this provision is 45 to 60 minutes of therapy.

Outpatient mental health services are Covered only when obtained from duly licensed: psychiatrists or practicing psychologists; or by certified social workers or mental hygiene facilities. Alcoholism and substance abuse related rehabilitation are not considered mental health services under this provision.

We Cover up to the amount of visits shown in your Summary of Benefits.

II. Precertification

All treatment received under this Rider must be precertified and described in Section I. Of your Certificate.

III. Coinsurance and Benefit Limitations

All covered Services under this Rider are subject to UCR, Deductible and the Coinsurance shown in your Summary of Benefits.

IV. Miscellaneous Provisions

All benefits are on a per Member, per calendar year basis.

The "Exclusions and Limitations," section of your Certificate is amended as follows:

a) The exclusion regarding inpatient alcohol and substance abuse treatment and detoxification is removed from the Certificate.

b) The exclusion regarding mental health services is removed from the Certificate.

This Rider supersedes any amendment or rider providing coverage for Mental Health and Substance Abuse previously issued by Us. In the event of a conflict between the provisions of this Rider and the Certificate, the provisions of this Rider will prevail. All other terms and conditions of the Certificate remain in full force and effect.

Nothing contained in this Rider will be held to vary, alter, waive, or extend any of the terms, conditions, provisions or limitations of the Agreement to which this Rider is attached, other than as specifically stated herein.

Exhibit H

Pursuant to Rule 5 of the United States District Court for the Southern District of New York Procedures For Electronic Case Filing only excerpts of the referenced document have been electronically filed due to the volume of the exhibit.

(This exhibit has been Bates Stamped and a complete copy is being served on plaintiff.).

This filing is without prejudice to any parties' right to supplement the exhibit or file the complete document.

9/1/05

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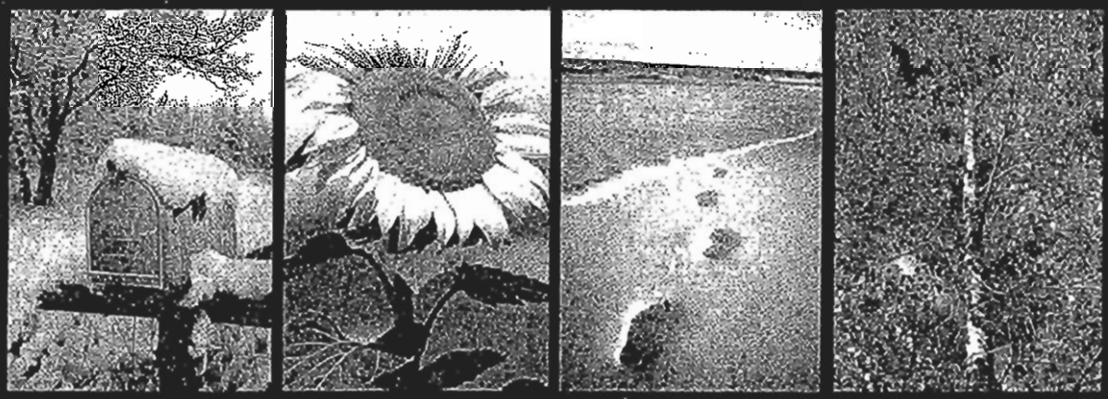
REDACTED

NEW YORK, NY 10028

Your Oxford Coverage
for all seasons



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FREEDOM PLAN®

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OXFORD
HEALTH PLANS®
A UnitedHealthcare Company

Dear Oxford Member,

Welcome, and thank you for selecting Oxford Health Plans.

Oxford wants to play an active role in your life and health by bringing quality, choice, and service to a higher level. We call this being a healthcare catalyst—where our access to a quality network, preventive programs, and practical resources are all working together to help you move to a healthier place. As an Oxford Member you have access to:

- A comprehensive network of doctors and hospitals
- Healthcare guidance 24 hours a day, seven days a week, from Oxford's registered nurses through *Oxford On Call®*
- *www.oxfordhealth.com*, Oxford's award-winning web site, which allows you to conduct transactions (e.g., request an ID card, change your primary care physician) and access health information quickly and easily
- A credentialed network of 2, 400 complementary and alternative medicine providers in Connecticut, New York, and New Jersey—including acupuncturists, chiropractors, nutritionists, message therapists, etc.
- Healthy Mind Healthy Body® magazine, your source for health information on prevention, nutrition, and exercise, as well as important benefit and coverage information

Enclosed is your new Summary of Benefits, Certificate of Coverage, and other important plan information. If you have questions about your coverage, please log in to *www.oxfordhealth.com* or call Customer Service at the number on your Oxford ID card.

To learn more about Oxford's programs that can help you achieve your best state of health, visit our web site at *www.oxfordhealth.com*.

Wishing you the best of health.

Sincerely,

Chuck

Chuck Berg
Chief Executive Officer

Enclosures

MS-02-1596 CT NY NJ 1/03

OXFORD HEALTH PLANS (NY), INC.

FREEDOM PLAN

SUMMARY OF BENEFITS

Entwistle & Cappucci LLP

PLEASE REVIEW THE MAXIMUMS AND LIMITATIONS (PAGES 7 & 8)

COVERED SERVICES	*IN-NETWORK	**OUT-OF-NETWORK
Primary and Preventive Care		
	Physician Office and Home Visits No Charge for Preventive Care visits.	Preventive care is available only to Members age 19 and under and is subject to Deductible and 20% Coinsurance.
	$10 copay per visit for treatment of illness or injury.	Office or home visits for treatment of illness or injury are Covered subject to Deductible and 20% Coinsurance.
	Two well-woman examinations, two Pap tests and age appropriate mammograms per Calendar Year are Covered No Charge.	Female Members may receive annual Pap tests and age appropriate mammogram subject to Coinsurance and Deductible. Well-woman examinations are not Covered.
Inpatient Hospital Visits	No Charge	Covered subject to Deductible and 20% Coinsurance.
Diabetes Education and Self-Management	$10 copay per visit.	Covered subject to Deductible and 20% Coinsurance.

*The In-Network benefits are provided through your HMO Certificate of Coverage & Member Handbook issued to you by Oxford Health Plans (NY), Inc. In order for a Covered Service to be Covered In-Network, the service must be obtained in accordance with terms and conditions of the HMO Certificate.

All Covered Services must be provided or arranged by the Member's PCP or Network Provider of OB/GYN care.

**The Out-of-Network benefits are provided through your Supplemental Certificate of Coverage and Member Handbook issued to you by Oxford Health Insurance, Inc. Covered Services are reimbursed only in accordance with its terms and conditions.

COVERED SERVICES	*IN-NETWORK	**OUT-OF-NETWORK
Primary and Preventive Care (cont.)		
Diabetic Supplies	$10 per 30-day supply of each item.	Covered subject to Deductible and 20% Coinsurance. **Precertification is required before the purchase of an insulin pump.**
Specialty Care		
Physician Office and Home Visits	$10 copay per visit.	Covered subject to Deductible and 20% Coinsurance.
Inpatient Hospital Visits	No Charge	Covered subject to Deductible and 20% Coinsurance.
Obstetrical Services (including prenatal and postnatal)	$10 copay per initial visit.	Covered subject to Deductible and 20% Coinsurance. **Precertification is required.**
Elective Termination of Pregnancy	No Charge	Covered subject to Deductible and 20% Coinsurance.
Basic & Comprehensive Infertility Services		
Outpatient	No Charge	Covered subject to Deductible and 20% Coinsurance. **Precertification is required.**
	Advanced Services are Not Covered.	**Advanced Services are Not Covered.**
Inpatient	No Charge	Covered subject to Deductible and 20% Coinsurance. **Precertification is required.**
	Advanced Services are Not Covered.	**Advanced Services are Not Covered.**
Office Visits	$10 copay per office visit.	Covered subject to Deductible and 20% Coinsurance.
	Advanced Services are Not Covered.	**Precertification is required.** **Advanced Services are Not Covered.**

COVERED SERVICES	*IN-NETWORK	**OUT-OF-NETWORK
Specialty Care (cont.)		
Allergy Testing and Treatment	$10 copay per visit.	Covered subject to Deductible and 20% Coinsurance.
Short-Term Rehabilitative Services (Physical, Speech and Occupational)		
Outpatient	$10 copay per visit.	Covered subject to Deductible and 20% Coinsurance.
Inpatient	No Charge	Covered subject to Deductible and 20% Coinsurance. **Precertification is required.**
Oral Surgery		
Outpatient	No Charge	Covered subject to Deductible and 20% Coinsurance.
Inpatient	No Charge	Covered subject to Deductible and 20% Coinsurance.
Office Visits	$10 copay per visit.	Covered subject to Deductible and 20% Coinsurance.
Pediatric Preventive Dental (through age 11)	No Charge	No Charge
Laboratory Procedures and X-ray Examinations	No Charge	Covered subject to Deductible and 20% Coinsurance. **Precertification is required for PET Scans, MRAs and surgical endoscopic procedures. MRIs, Bone Density Studies, Nuclear Medicine and CAT Scans will also require Precertification.**
Diagnostic Mammography	No Charge	Covered subject to Deductible and 20% Coinsurance.
Prosthetic Devices	No Charge for an internal prosthetic device.	Internal prosthetic devices are Covered subject to Deductible and 20% Coinsurance. Surgery is Covered subject to Deductible and 20% Coinsurance.
	External devices have no Copayment.	External Devices are Covered subject to Deductible and 20% Coinsurance. **Precertification is required.**

COVERED SERVICES	*IN-NETWORK	**OUT-OF-NETWORK
Specialty Care (cont.)		
Durable Medical Equipment	No Charge	Covered subject to Deductible and 20% Coinsurance. **Precertification is required on items that cost $500 or more.**
Medical Supplies	**No In-Network Benefit**	Covered subject to Deductible and 20% Coinsurance. **Precertification is required.**
Transplants	Transplants performed at Our approved facilities are Covered at No Charge. Transplants performed at other Network facilities are Covered on an Out-of-Network basis.	Covered subject to Deductible and 20% Coinsurance. **Precertification is required.**
Home Health Services	$10 copay per visit.	Covered subject to 20% Coinsurance. Not subject to Deductible. **Precertification is required.**
Chiropractic Services	$10 copay per visit.	Covered subject to Deductible and 20% Coinsurance.
Second Opinions	At your request $10 copay per visit. At Our request, No Charge.	Covered subject to Deductible and 20% Coinsurance.
Hospital and Other Facility Based Services		
Inpatient Hospital Services	No Charge	Covered subject to Deductible and 20% Coinsurance. **Precertification is required.**
Outpatient Hospital Services and Ambulatory Surgical Center Services	No Charge	Covered subject to Deductible and 20% Coinsurance. **Precertification is required.**
Skilled Nursing Facility Services	No Charge	Covered subject to Deductible and 20% Coinsurance. **Precertification is required.**

COVERED SERVICES	*IN-NETWORK	**OUT-OF-NETWORK
Hospital and Other Facility Based Services (cont.)		
Hospice Services		
Inpatient	No Charge	Covered subject to Deductible and 20% Coinsurance. **Precertification is required.**
Outpatient	No Charge	Covered subject to Deductible and 20% Coinsurance. **Precertification is required.**
Home Health Service	$10 copay per visit.	Covered subject to 20% Coinsurance. Not subject to Deductible. **Precertification is required.**
Skilled Nursing Facility Services	No Charge	Covered subject to Deductible and 20% Coinsurance. **Precertification is required.**
Alcohol and Substance Abuse Services		
Outpatient Alcohol and Substance Abuse Rehabilitation	No Charge	Covered subject to Deductible and 20% Coinsurance. **Precertification is required.**
Medical Emergency and Urgent Care Services		
Emergency Room Services	$50 copay per visit (Waived if a Member becomes confined in a hospital).	When proper notice is **not** given, Medical Emergency Admissions are Covered as described in the Supplemental Certificate subject to Deductible and 20% Coinsurance.
Urgent Care Facility Services	When proper notice is given, the services of Network and Non-Network Providers are Covered $10 copay per visit.	Covered subject to Deductible and 20% Coinsurance.
Ambulance Services	No Charge	All Covered Ambulance Services will be Covered as an In-Network benefit.

COVERED SERVICES **Supplemental Riders**	*IN-NETWORK	**OUT-OF-NETWORK
Outpatient Prescription Drugs:	**Triple tier:** $7 per Generic Prescription; $20 per Preferred Brand Name Prescription; and $40 per Non-Preferred Brand Name Prescription. All Copayments listed above apply to a 30-day supply of each prescribed drug. Mail Order Drugs: 2 Copayments for a 90-day supply.	Not Covered
Inpatient Mental Health Services	No Charge	Not Covered
Outpatient Mental Health Services	Covered subject to a Copayment of 50% of the cost of each visit.	Covered subject to Deductible and 50% Coinsurance. We pay a maximum benefit of $25 per visit. **Precertification is required.**
Inpatient Substance Abuse Rehabilitation and Detoxification	No Charge	Not Covered

COVERED SERVICES	*IN-NETWORK	**OUT-OF-NETWORK
Supplemental Riders (cont.)		

Important: Coverage under the Supplemental Certificate does not duplicate coverage under the HMO Certificate. Benefits are not cumulative. Benefits received under the Supplemental Certificate reduce the amount of benefits available under the HMO Certificate and Benefits received under the HMO Certificate reduce the amount of benefits available under the Supplemental Certificate.

MAXIMUMS AND LIMITATIONS

Unless otherwise indicated, the following maximums and limitations apply to both the In-Network and Out-of-Network Benefits combined.

All reimbursements for Out-of Network benefits are subject to UCR at the 90th percentile of HIAA.

Diabetic Supplies	Diabetic supplies will only be supplied in amounts consistent with the Member's treatment plan as developed by the Member's Physician. Only basic models of Blood glucose monitors are Covered unless the Member has special needs relating to poor vision or blindness.
Elective Termination of Pregnancy	We Cover one procedure per Member per Calendar Year. We pay a maximum benefit of $350 per procedure.
Short-Term Rehabilitation Therapy Services (Physical, Speech, Occupational)	
Inpatient	One consecutive 60-day period per condition, per lifetime.
Outpatient	90 visits per condition, per lifetime.
Durable Medical Equipment	We will pay a maximum benefit of $1,500 per Member, per Calendar Year.

MAXIMUMS AND LIMITATIONS (cont.)

Transplants	In-Network Coverage is available only at Network facilities specifically approved and designated by Us to perform these procedures.
Home Health Services	60 visits per Calendar Year.
Exercise Facility Reimbursement	Within one 6-month period We will reimburse you $200. We will reimburse your spouse $100 per 6-month period. The Member must complete 50 visits within the 6-month period.
Skilled Nursing Facility Services	30 days per Calendar Year.
Hospice Services	210 days (combined inpatient and outpatient).
Bereavement Counseling for Member's Family	5 sessions either before or after the death of the Member.
Outpatient Alcoholism and Substance Abuse Rehabilitation	60 visits per Calendar Year. Up to 20 of these visits may be used by the Member's family.

Supplemental Rider Information

Inpatient Mental Health Services	30 days per Calendar Year.
Outpatient Mental Health Services	30 visits per Calendar year.
Inpatient Alcoholism and Substance Abuse Rehabilitation	30 days per Calendar Year.
Detoxification	7 days per Calendar Year.

FAILURE TO PRECERTIFY

If you fail to obtain a required Precertification for an Out-of-Network benefit, you will be subject to a reduction in benefits. You must pay Deductible and 50% of the costs for such service or supply.

DEDUCTIBLES

The applicable Deductibles for this Plan are:

Out-of-Network Individual: $250

Family - A maximum of 2.5 times the Individual Deductible.

OUT-OF-POCKET MAXIMUM

The maximum amount you must pay in any Calendar Year for Out-of-Network Covered Services is $1,250 for an individual and 2.5 times per family.

Remember, only Coinsurance and the amounts paid to meet your Deductible count toward the Out-of-Pocket Maximum. Copayments for In-Network benefits, amounts in excess of the UCR, amounts paid for non-Covered Services, and any amounts paid as a penalty do not count toward the Out-of-Pocket Maximum.

Coinsurance paid for any Covered Service obtained under a Supplemental Coverage (excluding State mandated offers) will not be applied toward the Out-of-Pocket Maximums. Therefore, amounts paid for: outpatient prescription drugs will not be applied toward the Out-of-Pocket Maximum.

ELIGIBILITY LIMITS

The limiting ages for dependents (as defined in the HMO Certificate) are: under the age of 19 and between the ages of 19 and 23 for a full-time student. Coverage ends at the end of the Calendar Year.

EFFECTIVE DATES OF COVERAGE

Initial Enrollment (During the initial Group Open Enrollment Period.) Coverage is effective on the effective date of the Agreement.

Newly Eligible Employee (Application within 31 days of becoming eligible.) Coverage is effective on the date the employee became eligible.

Newly Eligible Dependents (Application within 31 days of becoming eligible). Coverage is effective on the date the dependent became eligible. Coverage is effective at birth for newborns and newly born adopted children subject to enrollment requirements as described in the Certificate.

Group Open Enrollment Period. Coverage will be effective on the renewal date of the Agreement.

IMPORTANT: This document is not a contract. It is only a summary of your coverage under the FREEDOM PLAN. Please read your HMO Certificate and your Supplemental Certificate for a full description of your Covered Services, exclusions and other terms and conditions of coverage.

IMPORTANT

This booklet contains your Certificates of Coverage and explains your new healthcare coverage. As a Member of the Oxford Freedom Plan®, each time you see a doctor you have the choice of seeking care on an In-Network basis through your Oxford primary care physician or on an Out-of-Network basis. In order to thoroughly explain your coverage, We provide you with TWO DIFFERENT CERTIFICATES, one for In-Network and one for Out-of-Network benefits.

In-Network Coverage

If you receive care from your Oxford Primary Care Physician or from an Oxford Network Specialist with an authorized referral, you are eligible for "In-Network" coverage. Your In-Network benefits and coverage are explained in the first half of your handbook. This part of your handbook has its own Table of Contents and "Getting Started" guide to your In-Network benefits.

Out-of-Network Coverage

If you receive Covered Services from a physician other than your Oxford Primary Care Physician, or from an Oxford Network Specialist without an authorized referral, you are eligible for "Out-of-Network coverage. Out-of-Network benefits and coverage are explained in the second half of your handbook. This supplemental Certificate of coverage restarts with its own Table of Contents and other "getting Started" guide to your benefits.

Each time you see a doctor, remember to look in the appropriate section of your handbook to determine your exact benefits. If you have any questions or need assistance, Our Customer Service Associates will be happy to help you. They are available at 800-444-6222, Monday through Friday, 8 AM to 6 PM, or after hours at 800-899-9039.

OXFORD HEALTH PLANS®

A UnitedHealthcare Company

OXFORD HEALTH PLANS (NY), INC.

Supplemental Certificate of Coverage
&
Member Handbook

This Certificate describes your Out-of-Network coverage under the Freedom Plan®.

SUPPLEMENTAL CERTIFICATE OF COVERAGE ("Certificate")
for
Oxford Health Insurance, Inc. ("Oxford")

Please read this entire Certificate carefully, including your Summary of Benefits, which contains information specific to your Group. These documents, and any attached riders, describe your rights and obligations and those of Oxford.

Under this Certificate, you engage Oxford to pay benefits for Covered medical and Hospital services in accordance with the terms and conditions of this Certificate and in reliance upon the statements you made in your application for coverage.

Oxford agrees with the Group to administer the Covered Services set forth in this Certificate, as may be amended from time to time by Oxford or the Group's Board of Directors. Please note:

- This Certificate and any riders, schedules or attachments have been delivered in consideration of the Group's timely payment of Premiums.
- No services are Covered under this Certificate in the absence of current payment of Premiums, subject to a 30-day Grace Period and the terms and conditions of the Certificate.
- No services are Covered under this Certificate unless coverage was in force at the time the service was obtained.
- In some instances, a medical procedure may not be Covered or may require Precertification. It is your responsibility to understand the terms and conditions in this Certificate.
- This Certificate cancels and replaces any prior Certificate issued to you by Oxford Health Insurance, Inc., for coverage under the Freedom Plan®.
- This Certificate is not in lieu of and does not affect any requirements for coverage by Workers' Compensation Insurance.
- This Certificate does not constitute the entire Agreement between Oxford Health Insurance, Inc., and the Group. While this Certificate has been made a part of the Group Enrollment Agreement, certain terms and conditions may only be described in the Group Enrollment Agreement itself. If questions arise, the terms of the Group Enrollment Agreement will govern. A copy of the Group Enrollment Agreement is available, upon request, from your employer.

This Certificate is governed by the laws of the State of New York.

D. Hospice

Hospice Care is available to Members who have a prognosis of six months or less to live. Coverage consists of palliative care rather than curative treatment. We Cover five visits for supportive care and guidance for the purpose of helping the Member and the Member's immediate family cope with the emotional and social issues related to the Member's condition. Hospice Care will be Covered only when provided as part of a Hospice Care program certified by the State of New York. Such certified programs may include Hospice Care delivered by: a Hospital (inpatient or outpatient), Home Healthcare Agency, Skilled Nursing Facility or a licensed Hospice Care facility. Coverage is limited to 210 days.

Coverage is not provided for: funeral arrangements; pastoral, financial or legal counseling; homemaker, caretaker or respite care.

4. ALCOHOLISM AND SUBSTANCE ABUSE

All services under this section require Precertification. You will be responsible for a greater portion of the cost of all services that are not Precertified.

Outpatient services for the diagnosis and treatment of alcoholism or substance abuse are limited to the amount of visits shown in your Summary of Benefits. The summary will also show the amount of visits which may be used by the Member's family. Outpatient services are limited to Hospitals or other facilities which are certified or licensed by the appropriate state regulatory authority.

Coverage for: detoxification for alcoholism and substance abuse; inpatient rehabilitation for alcoholism and substance abuse; inpatient mental health services; and outpatient mental health services are not Covered under this Certificate unless the Group has purchased a rider which adds these benefits. Please check your Summary of Benefits to verify what coverage you have available.

5. MEDICAL EMERGENCIES AND URGENT CARE

Medical Emergencies are Covered under your HMO Certificate regardless of wether they occur in or out of the Service Area. However, in those instances when you fail to access Emergency Care in accordance with the **procedures** required by the HMO (and the HMO denies coverage), coverage will be available under this Certificate, subject to Deductible, the penalty shown in your Summary of Benefits and UCR. This applies only to true Medical Emergencies. Coverage will not be provided when We determine that the use of the emergency room was improper.

Urgent Care services and the use of Urgent Care Centers are Covered under this Certificate, subject to Deductible, Coinsurance and UCR. No Precertification is required. In-Network coverage is available as described in your HMO Certificate.

6. AMBULANCE SERVICES

Medical Emergencies are Covered under your HMO Certificate. Transportation by Ambulance in connection with Medical Emergencies is also Covered under the HMO Certificate. Please check your HMO Certificate to determine what coverage is available.

Section IV.
Exclusions and Limitations

Unless coverage is specifically provided under this Certificate or provided under a rider or attachment to this Certificate, the following services and benefits are **not** Covered.

1. Services which are not Medically Necessary. If there is a dispute between a provider and Us about the Medical Necessity of a service or supply, you may appeal Our decision. Any disputed service or supply will not be Covered during the appeal process (please refer to the "Utilization Review Appeal" provision of the HMO Certificate).

2. A portion of the cost of services for which a required Precertification was not obtained.

3. Acupuncture therapy.

4. Adopted newly born infant's initial hospital stay if either of the natural parents has coverage available for the infant's care.

5. Alcohol and substance abuse treatment on an inpatient basis. Detoxification is not Covered.

6. Blood, blood plasma and blood derivatives other than those described as Covered under Section III of this Certificate. Synthetic blood, apheresis or plasmapheresis, the collection and storage of blood or the cost of securing the services of blood donors are not Covered.

7. Birth control pills, implantable contraceptive drugs, condoms, foams or devices, IUDs, diaphragms, contraceptive jellies and ointments, even if they are being prescribed or recommended for a medical condition other than birth control.

8. Care for conditions that by federal, state or local law must be treated in a public facility, including, but not limited to, commitments for mental illness. Additionally, to the extent allowed by law, we do not Cover care or treatment provided in a Hospital that is owned or operated by any federal, state or other governmental entity.

9. Comfort or convenience items, including but not limited to: barber services; guest meals and accommodations; telephone, television or radio charges; travel expenses; or take-home supplies. We also do not Cover the purchase or rental of household fixtures or equipment, including but not limited to: escalators; elevators; swimming pools; exercise cycles; air purifiers; air conditioners; water purifiers; allergenic pillows, mattresses or waterbeds.

10. Cosmetic, plastic or reconstructive surgery which is performed primarily to improve the appearance of any portion of the body, including but not limited to: surgery for sagging of extra skin; any augmentation or reduction procedure (e.g., mammoplasty); liposuction; keloids; rhinoplasty and associated surgery. Complications of such surgery are Covered only if they are Medically Necessary and are otherwise Covered. Remedial surgery is not Covered.

11. Court-ordered services or services that have been ordered as a condition of probation or parole. However, these services may be Covered if We agree that the services are Medically Necessary, the

Member has not exhausted his or her benefit for the calendar year, and the treatment is provided in accordance with Our policies and procedures.

12. Custodial care, domiciliary care, long-term care, maintenance care, adult day care or rest cures. We do not Cover room, board, nursing care or personal care which is rendered to assist a Member who, in Our opinion, has reached the maximum level of physical or mental function realistically possible and will not make further significant clinical improvement.

13. Dental services related to the care, filling, removal or replacement of teeth and the treatment of injuries or diseases of the teeth, gums and temporomandibular joint, including but not limited to: apicoectomy, orthodontics, root canals, soft tissue impaction, temporomandibular joint dysfunction therapy, alveolectomy, treatment of periodontal disease or orthognathic surgery. As described in Section III, 2, G, "Oral Surgery," only dental services required to treat accidental injury of sound, natural teeth are Covered.

14. Diabetes; limitations and exclusions. The Covered Services specified in this Certificate are Covered only as follows:

a. The items are Medically Necessary, as determined by Us, and are provided in amounts that are in accordance with a reasonable treatment plan developed by a Physician for the Member.

b. All requests for insulin pumps must first be reviewed by one of Our Medical Case Managers and approved by Our Medical Director.

c. Only basic models of blood glucose monitors will be covered, unless the Member has special needs relating to poor vision or blindness.

The following are not Covered:

a. Membership in health clubs, diet plans, or other organizations, even if recommended by a Physician or a Qualified Health Provider for the purpose of losing weight.

b. Any counseling or courses in diabetes management other than as described in this Certificate. Stays at special facilities or spas for the purpose of diabetes education/management.

c. Special foods, diet aids and supplements related to dieting.
d. Any item that is not both Medically Necessary and prescribed by the Member's Physician or Qualified Health Provider.

15. Durable Medical Equipment: We do not Cover: orthotics, arch supports, corrective shoes, false teeth, hearing aids.

16. Experimental, investigational or ineffective surgical or medical treatments, procedures, drugs, or research studies, including but not limited to: transplants, stem cell retrieval, cancer chemotherapy protocols, AIDS clinical trials or I.V. therapies that are not recognized as acceptable medical practice, and any such services where federal or other governmental agency approval is required but has not been granted. We will make the determination as to whether the requested service is excluded in accordance with this provision. In certain instances, such procedures may be Covered if they are approved in advance by Our Medical Advisory Board and provided in accordance with the provisions of this Certificate.

17. Emergency Care. Emergency Care is Covered only to the extent described in Section III, 5, "Medical Emergencies and Urgent Care," in this Certificate. Also excluded is improper use of an emergency room or emergency admissions. Routine care and treatment for conditions that We determine were not Medical Emergencies, when received in an emergency room, are not Covered.

18. Infertility treatment and supplies (except as otherwise Covered under this Certificate), even if the treatment or supply is for a purpose other than the correction of infertility. Services and supplies that are not Covered include but are not limited to: injectable infertility drugs such as Pergonal, Metrodin, etc., cost for an ovum donor or donor sperm, sperm storage costs, cryopreservation and storage of embryos, ovulation predictor kits, in-vitro services for women who have undergone tubal ligation, any infertility services if the male has undergone a vasectomy, and all costs for and relating to surrogate motherhood (maternity services are Covered for Members acting as surrogate mothers). We also do not Cover services to reverse voluntary sterilizations.

19. Learning and behavioral disorders. Services for the evaluation or treatment (including remedial education) of: learning disabilities or minimal brain dysfunction; mental retardation; developmental and learning disorders or behavioral problems. We also do not Cover behavioral training or cognitive rehabilitation.

20. When Medicare is the primary payor, We Cover the services provided by this Certificate only to the extent they are not Covered under Medicare.

21. Mental Health Services. Please check your Summary of Benefits to see if coverage of these services has been added through a rider.

22. Military service-related conditions. Conditions that are connected with a Member's service in the military and for which the Member is legally entitled to receive services at a government facility.

23. No-fault automobile insurance. Any personal injury benefits payable under mandatory no-fault automobile insurance or for Covered Services which are eligible for payment under the provisions of an automobile insurance contract or pursuant to any federal or state law which mandates indemnification for such services to persons suffering bodily injury from motor vehicle accidents, where permitted by law.

24. Non-eligible institutions. Any services or supplies furnished by a non-eligible institution, which is defined as other than a Hospital or Skilled Nursing Facility, and which is primarily a place of rest, a place for the aged, or any similar institution, regardless of how denominated.

25. Non-medical services and long-term rehabilitation services for physical therapy or the treatment of alcoholism or drug abuse, including rehabilitation services in a specialized inpatient or residential facility, except as specifically Covered under this Certificate.

26. No-show charges. If a Provider charges a fee for a missed appointment, you will be responsible for the payment of the fee.

27. Occupational conditions, ailments, or injuries arising out of and in the course of employment. Such conditions, ailments, or injuries are

Family and Medical Leave Act

Federal law provides that certain employees can take up to 12 weeks of unpaid leave in a 12-month period for the birth or adoption of a child, or for a serious health condition affecting the employee or a family member. Employers subject to this law are required to keep an employee's medical coverage in force to the same extent as if no leave had been taken. Your obligations, including any Premium contributions and compliance with Plan provisions, do not change during a leave.

If your employer is subject to this law, and you are eligible for leave under the Act, We will continue your coverage during a qualified leave. Coverage will terminate for failure to comply with Plan provisions, including the failure to pay Premium. You should check with your employer regarding family or medical leaves.

Section VIII.
Claims Procedures

1. FILING A CLAIM

According to the terms of this Certificate, you are financially responsible for the cost of any Covered Services received from non-Network Providers. When you receive Covered Services from a non-Network Provider, you must complete a claim form, sign it, and send it to Us with the **original**, itemized bill(s). Only original bills will be considered. Itemized bills should contain:

- Patient name
- Type of service
- Name and address of provider making the charge
- CPT-4 codes or HCPCS codes (description of services)
- Date of service
- Individual charge for each service
- ICD-9 codes (diagnosis or symptoms)

Be sure to keep a copy of your claim form and bills for your own records.

Claim forms are available from the Group or from Us by calling the Customer Service telephone number listed in the front of this Certificate. Completed forms should be sent to the address listed for "Claims" at the front of this Certificate.

All claims paid under this Certificate are subject to UCR.

2. PAYMENT OPTIONS

You may request Us to make payment directly to you or to the provider. If you want Us to pay the provider directly (referred to as assignment), you must give the provider a blank claim form to be completed and forwarded with the itemized bill.

If you decide to pay a provider directly, submit the completed claim form with your bill to Us for reimbursement, as described above. Although We will generally follow your instructions, We reserve the right to make the final determination.

3. LIMITATIONS

All requests for reimbursement must be made within 90 days of the date Covered Services were rendered. Failure to request reimbursement within the required time will not invalidate or reduce any claim if it was not reasonably possible to provide such proof within the 90-day period. However, such request must be made as soon as reasonably possible thereafter. Under no circumstances will We be liable for a claim that is submitted more than 180 days after the date services were rendered, unless you are legally incapacitated and unable to submit the request.

All reimbursements to non-Network Providers are subject to UCR.

4. CLAIM INFORMATION

Claims for Covered Services will be paid within 60 days after We receive proof of the claim. If necessary, Our Claims Department will contact you for more information regarding your claim in order to speed up the processing. If you would like to

inquire about the status of a claim, call the "Claims" telephone number listed in the front of this Certificate. Please have the date of service and your ID number ready.

5. CLAIM REVIEW (APPEAL)

We will provide you with an explanation for actions taken on each claim that you submit to Us. If you disagree with any decision, you may appeal through the Grievance Procedure, as described in the HMO Certificate.

6. NETWORK PROVIDERS

If you receive Covered Services from a Network Provider but not in accordance with the terms and conditions of the HMO Certificate, coverage will be provided under this Certificate. When you see a Network Provider under these circumstances, the Covered Services will be treated as if they were delivered by a non-Network Provider, and you must file a claim, as described above.

Section IX.
Other Important Documents

1. SUPPLEMENTAL COVERAGE BY RIDER

The terms and conditions of this Certificate are subject to revision, addition, or deletion. Any such changes will be made by a rider. The terms of a rider that is issued by Us and accepted by the Group will supersede conflicting terms in this Certificate. Riders that are part of your Plan will be issued with your Certificate. You should check your Summary of Benefits or verify with the Group whether your Plan is subject to any rider.

Please check with your Benefits Administrator to make sure you have the most recent documents concerning your supplemental coverage under the Plan.

her choice. He or she must also pay any required Premium. Any Subscriber who elects Medicare as primary will not be eligible for coverage under this Certificate as of the date of this election.

Section XI.
General Provisions

1. Entire Agreement. This Certificate, the HMO Certificate, the Freedom Plan® Summary of Benefits, any Certificate riders issued to and accepted by the Group, the Group Enrollment Agreements, and the individual applications of you and your Covered Dependents, if any, constitute the entire contract between the parties and, as of the effective date hereof, supersede all other agreements between the parties. Any and all statements made to Us by the Group and any Subscriber or Covered Dependent will, in the absence of fraud, be deemed representations and not warranties, and no such statement, unless it is contained in a written application for coverage under this Certificate, shall be used in defense to a claim under this Certificate.

2. Form or Content of Certificate. No agent or employee of Us is authorized to change the form or content of this Certificate. Such changes can be made only through an endorsement authorized and signed by one of Our officers.

3. Identification Cards. Cards issued by Us to Members are for identification only. Possession of an identification card confers no right to services or other benefits, under this Certificate. To be entitled to such services or benefits the holder of the card must, in fact, be a Member on whose behalf all applicable Premiums under this Certificate and the HMO Certificate have actually been paid. Any person receiving services or other benefits to which he is not then entitled pursuant to the provisions of this Certificate will be liable for the actual cost of such services or benefits.

4. Notice. Any notice required under this Certificate may be given to Us by U.S. Mail, first class, postage prepaid, to the Customer Service address listed in the front of the Certificate. Notice to a Member will be sent to the last address We have for that Member. Member agrees to provide Us with notice, within 31 days, of any change of address.

5. Interpretation of Certificate. The laws of the State of New York shall be applied to interpretations of this Certificate.

6. Assignment. This Certificate is not assignable by Group without Our written consent. Any benefits under this Certificate are not assignable by any Member without Our written consent. In addition, This Agreement shall not confer any rights or obligations on third parties except as specifically provided herein.

7. Gender. The use of any gender in this Certificate is deemed to include the other gender, and, whenever appropriate, the use of the singular is deemed to include the plural (and vice versa).

8. Modifications. By this Certificate, the Group makes Our coverage available to Members who are eligible under the terms of the Certificate. However, this Certificate is subject to amendment, modification and termination in accordance with this provision, the Group Enrollment Agreement or by mutual agreement between Us and Group's Board of Directors, without the consent or concurrence of any Member. By enrolling in this Plan, all Members legally capable of contracting, and the legal representatives of all Members incapable of contracting, agree to all its terms, conditions, and provisions.

9. Clerical Error. Clerical error, whether by the Group or Us, with respect to this Certificate or any other documentation issued by Us in connection with this Certificate, or in keeping any record pertaining to the coverage hereunder, will not modify or invalidate coverage otherwise validly in force or continue coverage otherwise validly terminated.

10. Policies and Procedures. We may adopt reasonable policies, procedures, rules and interpretations to promote the orderly and efficient administration of this Certificate with which Members shall comply.

11. Waiver. The waiver by any party of any breach of any provision of the Agreement will not be construed as a waiver of any subsequent breach of the same or any other provision. The failure to exercise any right hereunder will not operate as a waiver of such right.

12. Termination of the Agreement. The Agreement will continue in effect for the period of time specified in the Agreement and may be canceled in accordance with the terms of the Agreement.

13. Incontestability. Except as to a fraudulent misstatement: No statement made by the Group or any Member will be the basis for voiding coverage or denying coverage or be used in defense of a claim unless it is in writing. No statement made by the Group will be the basis for voiding the Agreement after it has been in force for two years from its effective date.

14. Independent Contractors. All providers (Network and non-Network) are independent contractors. They are not Our agents or employees. We and Our employees are not the agent or employee of any provider. We are not liable for any claim or demand on account of damages arising out of, or in any manner connected with, any injuries alleged to be suffered by any Member while receiving care from any provider or in any provider's facility.

15. Limitation on Payment. We will not pay an amount that is more than a provider charged for Covered Services or that is more than the UCR charges, nor will we credit such an amount toward the deductible or Out-of-Pocket Maximum.

Section XII.
Definitions

Defined terms will appear capitalized throughout the Agreement.

Acute: The sudden onset of disease or injury, or a sudden change in the Member's condition that would require prompt medical attention.

Agreement: The Group Enrollment Agreement between Oxford Health Insurance, Inc., and the Group, including any attachments and this Certificate, and the Group Enrollment Agreement between Oxford Health Plans (NY), Inc., and the Group, including any attachments and the HMO Certificate.

OXFORD HEALTH PLANS

Oxford Health Insurance, Inc.

Mental Health and Substance Abuse Rider

Your Certificate of Coverage & Member Handbook ("Certificate") is revised as follows:

I. Out-of-Network Coverage

Mental Health Services

Outpatient

We cover outpatient visits for the treatment of mental or nervous disorders. A "visit" for the purposes of this provision is 45 to 60 minutes of therapy.

Outpatient mental health services are Covered only when obtained from duly licensed: psychiatrists or practicing psychologists; or by certified social workers or mental hygiene facilities. Alcoholism and substance abuse related rehabilitation are not considered mental health services under this provision.

We Cover up to the amount of visits shown in your Summary of Benefits.

II. Precertification

All treatment received under this Rider must be precertified and described in Section I. Of your Certificate.

III. Coinsurance and Benefit Limitations

All covered Services under this Rider are subject to UCR, Deductible and the Coinsurance shown in your Summary of Benefits.

IV. Miscellaneous Provisions

All benefits are on a per Member, per calendar year basis.

The "Exclusions and Limitations," section of your Certificate is amended as follows:

a) The exclusion regarding inpatient alcohol and substance abuse treatment and detoxification is removed from the Certificate.

b) The exclusion regarding mental health services is removed from the Certificate.

This Rider supersedes any amendment or rider providing coverage for Mental Health and Substance Abuse previously issued by Us. In the event of a conflict between the provisions of this Rider and the Certificate, the provisions of this Rider will prevail. All other terms and conditions of the Certificate remain in full force and effect.

Nothing contained in this Rider will be held to vary, alter, waive, or extend any of the terms, conditions, provisions or limitations of the Agreement to which this Rider is attached, other than as specifically stated herein.

EXHIBIT I

OXFORD HEALTH PLANS®
A UnitedHealthcare Company

602040 4129

Large Group Enrollment Form

Oxford Health Insurance, Inc.

Please print all information, using ink.

Type of Action: ☐ New ☒ Renewal ☐ Revision ☐ Correction ☐ Termination

Effective Date of Action: 2/1/06

EMPLOYER INFORMATION

Group Name: Entwistle + Cappucci, LLP **Group ID Number (if known):** EC1227

Contract/Renewal Date: 9/1/06 **Acronym (Optional):** _____ **SIC:** 8111

TAX ID (9 digits): 13 REDACTED **Nature of Business:** _____

Type of Group: ☐ Corporation ☐ Trust ☒ Partnership ☐ Association
☐ Fed Emp - FEHBP ☐ Union ☐ Govt Employee __State __County __Local __School Board

ADDRESSES & CONTACTS

Administrative Address & Contact (Cannot be a P.O. Box)
Contact Name: Stella Ivanova Title: Director of HR
Phone: (212) 894-7223 Fax: ( ) E-mail:
Street: 280 Park Avenue
City: New York State: NY Zip Code: 10017
Group Name:

Billing Address & Contact (If different from above.)
Contact Name: John Giviola Title: Billing Rep.
Phone: (914) 273-4723 Fax: ( ) E-mail:
Street: 80 Business Park Dr Suite 306
City: Armonk State: NY Zip Code: 10504
Group Name:

GEA Address & Contact (If different from above.) *Add Comment in Remarks "GEA ADDRESS" H.O. use only*
Contact Name: Title:
Phone: ( ) Fax: ( ) E-mail:
Street:
City: State: Zip Code:
Group Name:

Which address is primary?* RECEIVED JAN 17 2006

*If not indicated otherwise, the first address will be primary.

Date Prepared 1/16/05 **Sales Representative** Shawn Connolly **Account Manager/ DGSA** _____
Group ID# EC1227 **Underwriter** _____ **Underwriting Associate** DK

ELIGIBILITY/TERMINATION INFORMATION

New Hires

CSP____ Or All CSPs X

A. Class/Location: All Eligible EE's

☐ First day of month following waiting period/ Last day of the month in which employment terminates

☒ Date employee completes waiting period/ Date employment terminates

Waiting period 30 days/____months

B. Class/Location: _____

☐ First day of month following waiting period/ Last day of the month in which employment terminates

☐ Date employee completes waiting period/ Date employment terminates

Waiting period ____days/____months

CSP____

A. Class/Location: _____

☐ First day of month following waiting period/ Last day of the month in which employment terminates

☐ Date employee completes waiting period/ Date employment terminates

Waiting period ____days/____months

B. Class/Location: _____

☐ First day of month following waiting period/ Last day of the month in which employment terminates

☐ Date employee completes waiting period/ Date employment terminates

Waiting period ____days/____months

Note: If more than two CSPs, please attach additional pages.

Eligibility lag for **present** employees

☒ Same as new hires (standard)
☐ None (H.O. Approval)

Eligibility lag waived for **rehires**

☒ Yes (if rehired within Indefinitely)
☐ No

Dependent Cut Off

☒ 19 (Standard)
☐ Other (H.O. Approval)* _____

Student Cut Off

☒ 23 (Standard)
☐ 25 (H.O. Approval)*
☐ Other (H.O. Approval)* _____

**Note: Additional charge will be applied to rates.*

Dependent Benefits Discontinued**

☒ Last day of semester in which birthday occurs
☐ Last day of calendar year in which birthday occurs
☐ To be administered by group and requires a letter from the Benefits Administrator.

*** Please note: Must choose end of calendar year or end of semester, unless an exception has been made in the section labeled "NONSTANDARD OPEN ENROLLMENT PROCEDURES" (see page 4), or the dependent and student cut off age are identical (23,23; 25,25)*

Employee Counts

☒ Full Time 83 Hours 30
☐ Part Time _____ Hours _____
☐ Retired _____
☐ Union _____
☐ Other _____
Total Eligible _____

Policies

Leave of absence policy: ☒ Yes 90 days (max. 90 days) ☐ No

Retro enroll/disenroll policy: ☒ Yes 31 days (max. 31 days) ☐ No

Conversion: ☒ Yes ☐ No

Date Prepared 6/27 Sales Representative Shawn Connolly Account Manager/ DGSA _____

Group ID# 1/1/06 Underwriter _____ Underwriting Associate DK

OPEN ENROLLMENT

☒ Yes ☐ No **If yes, complete the information.**

☒ Approved Non-Standard Group Administration Form attached

Open enrollment period: From 1/1/06 Through 1/31/06

To be effective: 2/1/06

☐ Limited Open Enrollment (Describe Limitation)_____

NONSTANDARD OPEN ENROLLMENT PROCEDURES

Note: Any of the following nonstandard member enrollment procedures must be pre-approved by the Home Office. Approval requires a letter from the policyholder that indicates they will be responsible for the validation of the member, instead of Oxford Health Plans Employer Services. These procedures will not be supported without:

a) a policyholder letter and/or Electronic Enrollment Agreement and;

b) indication on the GEF to allow a notation in the system.

These exceptions must apply to all employees. They may not be implemented for specific employees only.

☐ Approved Non-Standard Group Administration Form attached

Check all that apply

☐ Date of Marriage is not required on enrollment tape/paper or forms to enroll member

☐ Student verification date is neither calendar year nor semester (OXHP standard), and policyholder will verify student status and terminate dependent

☐ Benefit Administrator's signature is not required on enrollment tape/paper or forms to enroll member

☐ Date of Hire is not required on enrollment tape/paper or forms to enroll member

HEALTH PERCENTAGE OF EMPLOYER CONTRIBUTIONS

Employee coverage 90% Family/Dependent coverage 90% of Single

SELF-FUNDED INFORMATION

☐ Yes ☐ No **If yes, complete the following information.**

☐ New plan ☐ Takeover of prior plan

☐ Confirmation of sold rates attached

Specific Stop Loss: $_____

☐ Incurred

Aggregate Stop Loss

☐ 125% (Standard)

NonStandard Aggregate Funding (H.O. Approval)

Run out ☐ No ☐ Yes _____Days (90 day standard) ☐ Other _____

Funding Arrangement:

☒ Automated clearing house (ACH)

☐ Weekly wire transfer

☐ Check

☐ Imprest Account (Standard, 4 week balance)

Replenish: ☐ Wire ☐ Check

Date Prepared 1/16/06 Sales Representative [illegible] Account Manager/ DGSA _____

Group ID# EC1227 Underwriter _____ Underwriting Associate DK

CSP(s)* All Eligible 0802 602040 4132

*Note: If more than one CSP, please attach additional pages.

PLAN DESIGN

☒ Full Conversion ☐ Approved NSB Paperwork attached Product Code_____(H.O.Use Only)

☐ Offering

PRODUCTS
- ☐ HMO
- ☐ HMO Plan Select*
- ☒ Freedom Plan POS Classic
- ☐ Freedom Plan Select*
- ☐ Freedom Plan Preferred
- ☐ Freedom Plan PPO*

* Non-Gatekeeper Plans

STATE
- ☒ NY
- ☐ NJ
- ☐ CT
- ☐ PA
- ☐ Other_____(H.O. Approval)

UCR
- ☐ Standard
- ☐ High
- ☒ Very High

NETWORK
- ☒ Freedom
- ☐ Liberty
- ☐ First Health (Formerly Affordable)
- ☐ Other _____(H.O. Approval)

OFFICE COPAY
PCP/OB-GYN
- ☐ $5
- ☐ $10
- ☐ $15
- ☐ $20
- ☒ Other $10/$15 (H.O. Approval)

ER COPAY
- ☐ $25
- ☐ $30
- ☐ $35
- ☒ $50
- ☐ Other _____(H.O. Approval)

HOSPITAL COPAY
- ☒ NONE
- ☐ $100
- ☐ $250
- ☐ $500
- ☐ Other _____(H.O. Approval)

COMPONENTS OF MAJOR MEDICAL

FREEDOM PLAN

EXAMPLE: **Deductible:** 250/500 (Multiple = 2) **Coinsurance:** 80/20 **Maximum:** $5,000

The member is responsible for their single deductible (250), then 20% of $5,000 would be $1,000. The maximum amount the member would pay out of their pocket would be $1,250.

Check the appropriate Family Multiple ☐ 2 ☒ 2.5 ☐ 3

DEDUCTIBLE

IN- NETWORK (Insurance PPO Only)
Single $_____ Family $_____
4th Qtr. Carry Over ☐ No (Standard) ☐ Yes (H.O. Approval)
Prior Carrier Deductible ☐ No ☐ Yes (H.O. Approval)

OUT- OF-NETWORK
Single $ 3,000 Family $ 7,500
4th Qtr. Carry Over ☒ No (Standard) ☐ Yes (H.O. Approval)
Prior Carrier Deductible ☒ No ☐ Yes (H.O. Approval)

COINSURANCE

IN- NETWORK (Insurance PPO Only)
- ☒ 100/0
- ☐ 90/10
- ☐ 80/20
- ☐ 70/30
- ☐ Other _____(H.O. Approval)

4th Qtr. Carry Over ☒ No (Standard) ☐ Yes (H.O. Approval)

OUT- OF-NETWORK
- ☒ 80/20
- ☐ 70/30
- ☐ Other _____(H.O. Approval)

COINSURANCE MAXIMUM
- ☒ $5,000
- ☐ $10,000
- ☐ Other _____(H.O. Approval)

MAXIMUM BENEFIT

FREEDOM PLAN (Lifetime)
☐ $1,000,000 ☒ Unlimited ☐ Other _____(H.O. Approval)

Date Prepared 1/1/06 Sales Representative Shawn Connolly Account Manager/ DGSA _____
Group ID# EC227 Underwriter _____ Underwriting Associate DK

CSP(s)* CSP02 - All Eligible

*Note: If more than one CSP, please attach additional pages.

602040 4133

PHARMACY RIDERS

PCS ☒ Yes ☐ No PCS Group # _____ (H. O. Use Only) Plan # _____ (H. O. Use Only)

Contraceptives ☒ Yes ☐ No Other drug coverage _____ (H. O. Use Only)

PCS Co-pay
- ☐ $2/$5 ☐ $5/$15
- ☐ $5/$10 ☐ $7/$20
- ☒ Other Approved Options [redacted] $7/$20/$50

Maximum Benefit Year Cap Limit
- ☒ No maximum amount
- ☐ $3,000
- ☐ Other _____ (H.O. Approval)

Deductible
- ☒ No deductible
- ☐ Yes $_____

Mail Order (MAC-A does NOT have mail order)
- ☒ Yes
- ☐ No

Payment Policy
- ☐ MAC-A
- ☐ MAC-C

MEDICAL RIDERS

Check the riders that have been purchased.

- ☒ **Durable Medical Equipment (DME)** $ 1500
- ☐ **Medical Supplies**
- ☐ **Unlimited Skilled Nursing Facility (SNF)**
- ☐ **Alternative Medicine** _____ (Specify Rider)
- ☐ **Enhanced Chiropractic Care ($1,000 eligible) NJ, CT, PA only**
- ☐ **Home Health Care** _____ (Specify Rider)
- ☐ **Infertility** _____ (Specify Rider)
- ☐ **Mental Health** _____ (Specify Rider)
- ☐ **Prosthetics (Repair & Replacement)**

Domestic Partnership (H.O. Approval)
- ☐ Same Gender
- ☐ Same Gender/Opposite Gender

Vision
- ☐ $50 Exam per 12 months/$70 Appliance per 24 months
- ☐ Other (Specify) _____

Outpatient Physical Therapy
- ☐ 90 visits per condition/lifetime
- ☐ 60 visits per condition/lifetime

Dental
- ☐ Enhanced HMO
- ☐ Premium HMO

☐ **Other (H.O. Approval) - List Below:**
- ☐ Approved NSB Form attached

_____

_____

_____

_____

_____

_____

Date Prepared 1/16/06 Sales Representative Shawn Connelly Account Manager/ DGSA _____

Group ID# EC7227 Underwriter _____ Underwriting Associate DK

CSP(s)* CSPDL D of USA

*Note: If more than one CSP, please attach additional pages.

602040 4134

PLAN DESIGN

☒ Full Conversion
☐ Offering

☐ Approved NSB Paperwork attached

Product Code _____ (H.O.Use Only)

PRODUCTS
- ☐ HMO
- ☐ HMO Plan Select*
- ☐ Freedom Plan POS
- ☒ Freedom Plan Select*
- ☐ Freedom Plan Preferred
- ☐ Freedom Plan PPO*

* Non-Gatekeeper Plans

STATE
- ☒ NY
- ☐ NJ
- ☐ CT
- ☐ PA
- ☐ Other _____ (H.O. Approval)

UCR
- ☐ Standard
- ☐ High
- ☒ Very High

NETWORK
- ☐ Freedom
- ☐ Liberty
- ☒ First Health (~~Formerly Affordable~~) Choice Plus
- ☐ Other _____ (H.O. Approval)

OFFICE COPAY
PCP/OB-GYN
- ☐ $5
- ☐ $10
- ☐ $15
- ☐ $20
- ☒ Other $0/$15 (H.O. Approval)

ER COPAY
- ☐ $25
- ☐ $30
- ☐ $35
- ☒ $50
- ☐ Other _____ (H.O. Approval)

HOSPITAL COPAY
- ☒ NONE
- ☐ $100
- ☐ $250
- ☐ $500
- ☐ Other _____ (H.O. Approval)

COMPONENTS OF MAJOR MEDICAL

FREEDOM PLAN

EXAMPLE: **Deductible:** 250/500 (Multiple = 2) **Coinsurance:** 80/20 **Maximum:** $5,000

The member is responsible for their single deductible (250), then 20% of $5,000 would be $1,000. The maximum amount the member would pay out of their pocket would be $1,250.

Check the appropriate Family Multiple ☐ 2 ☒ ~~2.5~~ ☐ 3

DEDUCTIBLE

IN- NETWORK (Insurance PPO Only)
Single $ N/A Family $ N/A
4th Qtr. Carry Over ☐ No (Standard) ☐ Yes (H.O. Approval)
Prior Carrier Deductible ☐ No ☐ Yes (H.O. Approval)

OUT- OF-NETWORK
Single $ 3,000 Family $ 7,500
4th Qtr. Carry Over ☐ No (Standard) ☐ Yes (H.O. Approval)
Prior Carrier Deductible ☐ No ☐ Yes (H.O. Approval)

COINSURANCE

IN- NETWORK (Insurance PPO Only)
- ☒ 100/0
- ☐ 90/10
- ☐ 80/20
- ☐ 70/30
- ☐ Other _____ (H.O. Approval)

4th Qtr. Carry Over ☒ No (Standard) ☐ Yes (H.O. Approval)

OUT- OF-NETWORK
- ☒ 80/20
- ☐ 70/30
- ☐ Other _____ (H.O. Approval)

COINSURANCE MAXIMUM
- ☒ $5,000
- ☐ $10,000
- ☐ Other _____ (H.O. Approval)

MAXIMUM BENEFIT

FREEDOM PLAN (Lifetime)
☐ $1,000,000 ☒ Unlimited ☐ Other _____ (H.O. Approval)

Date Prepared 1/16/06 Sales Representative Shawn Connolly Account Manager/ DGSA _____

Group ID# EE027 Underwriter _____ Underwriting Associate DK

CSP(s)* CSP02 Ox USA

*Note: If more than one CSP, please attach additional pages.

602040 4135

PHARMACY RIDERS

PCS ☒ Yes ☐ No PCS Group # _____ (H. O. Use Only) Plan # _____ (H. O. Use Only)

Contraceptives ☒ Yes ☐ No Other drug coverage _____ (H. O. Use Only)

PCS Co-pay
- ☐ $2/$5 ☐ $5/$15
- ☐ $5/$10 ☐ $7/$20
- ☒ Other Approved Options 7/20/50

Maximum Benefit Year Cap Limit
- ☒ No maximum amount
- ☐ $3,000
- ☐ Other _____ (H.O. Approval)

Mail Order (MAC-A does NOT have mail order)
- ☒ Yes
- ☐ No

Deductible
- ☒ No deductible
- ☐ Yes $_____

Payment Policy
- ☐ MAC-A
- ☐ MAC-C

MEDICAL RIDERS

Check the riders that have been purchased.

- ☒ **Durable Medical Equipment (DME)** 450 MAX
- ☐ **Medical Supplies**
- ☐ **Unlimited Skilled Nursing Facility (SNF)**
- ☐ **Alternative Medicine** _____ (Specify Rider)
- ☐ **Enhanced Chiropractic Care ($1,000 eligible) NJ, CT, PA only**
- ☐ **Home Health Care** _____ (Specify Rider)
- ☐ **Infertility** _____ (Specify Rider)
- ☐ **Mental Health** _____ (Specify Rider)
- ☐ **Prosthetics (Repair & Replacement)**

Domestic Partnership (H.O. Approval)
- ☐ Same Gender
- ☐ Same Gender/Opposite Gender

Vision
- ☐ $50 Exam per 12 months/$70 Appliance per 24 months
- ☐ Other (Specify) _____

Outpatient Physical Therapy
- ☐ 90 visits per condition/lifetime
- ☐ 60 visits per condition/lifetime

Dental
- ☐ Enhanced HMO
- ☐ Premium HMO

- ☐ **Other (H.O. Approval) - List Below:**
  - ☐ Approved NSB Form attached

_____

_____

_____

_____

_____

_____

Date Prepared 1/16/06 Sales Representative Shawn Connolly Account Manager/ DGSA _____

Group ID# EC1227 Underwriter _____ Underwriting Associate DK

CONTRACT PREMIUMS

COBRA/State Continuation

☐ Bill employer (Commercial) ☐ Bill Subscriber (Non-group – 2% added to active rate)

Employee Type Tier Options	EE All	EE/Child 4T, 5T	Double 3T	Couple 4T, 4TA, 5T	EE/ Children 4TA, 5T	Family All
CSP 02 Total	417.99	—	—	856.67	721.28	1,260.36
CSP 02 Total	436.49			894.80	753.38	1,316.45
CSP_____ Total						
CSP_____ Total						

Note: If more than 4 CSPs, please attach additional pages

TIER STRUCTURE Double = (EE/Spouse, EE/Child) Couple = (EE/Spouse)

2T	Employee;	Family			
3T	Employee;	Double;	Family		
4T	Employee;	Couple;	Employee/Child;	Family	
4TA	Employee;	Couple;	Employee/Children;	Family	
5T (PA only)	Employee;	Couple;	Employee/Child;	Employee/Children;	Family

Rates Approved DK 11/9/2006

COMMISSIONS

If more than 2 Brokers, check here ☐ and attach separate sheet, (if first case through Broker, attach copy of license and Oxford Agreement).

Select One Sales Distribution channel: ☐ Direct ☒ Broker ☐ General Agent

Oxford Account Executive Shawn Connolly Split 100 %

Office Location/ Sales Unit NYC / SBU

Oxford Account Executive _____ Split _____ %

Office Location/ Sales Unit _____

BROKER/GENERAL AGENT INFORMATION

☒ Total Commission Payable (Fully Insured) 6 %

☐ $_____ per contract (Self-Funded)

Percent split 6 %

$_____ split per contract (Self-Funded)

Code BC0133

Agency Name Michaels + Associates

Broker/Agent Name Michele Gasparre

Address 86 Business Pk Dr. Armonk, NY

Contact _____

Telephone 914-273-4723

E-mail _____ Fax _____

SS# or Fed. Tax I.D.# _____

Percent split _____ %

$_____ split per contract (Self-Funded)

Code _____

Agency Name _____

Broker/Agent Name _____

Address _____

Contact _____

Telephone _____

E-mail _____ Fax _____

SS# or Fed. Tax I.D.# _____

Date Prepared 1/16/06 Sales Representative Shawn Connolly Account Manager/ DGSA _____

Group ID# EC02 Underwriter _____ Underwriting Associate DK

SUMMARY OF SUBMISSION

	Pages to Reference
This Group is Converting from a small Plan to a Large plan I have Included - Group App, Evaluation, NY345 Enrollment forms. They also have an OxUSA Plan Their mirrors the Dr Aron Plan.	

Exception Highlights

- ☐ Approved Non-Standard Benefits (NSB) Form attached (Plan Design Only)
- ☐ Approved Non-Standard Group Administration Form attached (Operational Only)

	Pages to Reference
Risk and Rates Approved DK 1/19/2006	

****Please Note: Appropriate form is required for any H.O. Approval option.**

Date Prepared 1/16/05 Sales Representative Shawn Bradley Account Manager/ DGSA _____

Group ID# EC 1227 Underwriter _____ Underwriting Associate DK

602040 4138

Plan Design and Rates:

	High Plan	Low Plan
Product:	Gated	Non-Gated
Network:	Freedom	Choice Plus
PCP Office Copay:	$10	$10
Specialist Copay	$15	$15
ER Copay:	$50	$50
In-network Deductible	N/A	N/A
In-network Coinsurance	100%	100%
Out of Network Ded	$3,000	$3,000
Out of Network Coins	80% to $5,000	80% to $5,000
OON UCR	90th Percentile	90th Percentile
Rx card:	$7/$20/$50	$7/$20/$50
Rx Deductible:	$0	$0
Riders:	DME $1500 Max 2X Mail Away Rx	DME $1500 Max 2X Mail Away Rx
Single	$417.89	$436.49
Couple	$856.67	$894.80
EE/Children	$721.28	$753.38
Family	$1,260.36	$1,316.45

As you may know, Oxford has the flexibility to tailor plan designs to meet the needs of any employer. Feel free to call me with any questions you may have the quotes I have provided or any other Oxford products the group may have an interest in.

Once again, thank you for using the quality products and services of Oxford Health Plans. I am looking forward to speaking with you regarding the status of this prospect shortly.

Sincerely,

Shawn Connolly
Account Executive
(212) 912-4006

EXHIBIT J

Oxford Health Insurance, Inc.
Oxford Group Enrollment Agreement

6104104518

Group Name: Entwistle & Cappucci LLP ("Group")
Group Numbers: EC1227*03U,03UC Effective Date: February 1, 2006

Definitions

· Agreement: This Group Enrollment Agreement, the Group Application, the individual applications of the Members, the Certificate of Coverage and Member Handbook, the Summary of Benefits and any applicable Riders.

· OHI, Us, We, Our: Oxford Health Insurance, Inc.

· Members: Subscribers and Covered Dependents.

· Terms not defined in this Group Enrollment Agreement will have the meaning set forth in the Certificate.

In consideration of the payment of Premiums, OHI and Group agree that OHI will arrange or pay for Covered medical and hospital services in accordance with the terms and provisions of the Agreement. Such services will be provided for the Group's eligible employees (Subscribers) and their Covered Dependents.

I. EFFECTIVE DATE AND TERMS OF AGREEMENT:

The Agreement will be effective on the 1st day of February, 2006, at 12:00 a.m. Eastern Time and will remain in effect for a period of 12 consecutive months, ending on the 31st day of January, 2007 at 11:59 p.m. Eastern Time, at which time coverage will terminate (the "Initial Contract Period"). The Agreement, and the coverage provided under the Agreement, will automatically renew after the end of the Initial Contract Period or any Subsequent Contract Period unless it would otherwise terminate in accordance with Section XIII of this Group Enrollment Agreement.

II. COVERAGE:

Benefit Plan Code/Description: Access Oxford USA Plan, UnitedHealthcare Choice Plus Network, Very High UCR, $10 PCP/$15 Specialist Copay
Deductible: $3,000 Single/$7,500 Family
Coinsurance: 80%/20% to $10,000 (see attached summary of benefits)

Optional Benefit Riders: Prescription:
$7 Copay Per Generic Drug
$20 Copay Per Preferred Brand Drug
$50 Copay Per Brand Name Drug
No Prescription Maximum
Includes Contraceptives

III. PREMIUM RATE SCHEDULE:

6104104519

Type of Coverage	Total Monthly Premium
Single	$436.49
Family	$1316.45
Parent/Children	$753.38
Couple	$894.80

IV. ELIGIBILITY:

Eligible employees of the Group will be full-time employees of the Group who work a minimum of 30 hours per week. In addition, eligible employees of the Group and their eligible family members will meet the eligibility criteria set forth in the Certificate and the requirements set forth below:

Subscribers (Employees): Ox USA: Subscribers will be eligible on the date occurring 30 days after commencement of employment. Coverage ends on the date of termination.

Such waiting period is waived for employees rehired within any time period after an approved leave of absence.

Covered Dependents: The legal spouse of the Subscriber and any unmarried, dependent children, as defined in the Certificate, are eligible for coverage. Such children are eligible until the child reaches age 19 or age 23 if child is a full-time student. Coverage ends at the end of calendar year.

The eligibility requirements listed in this section of this Group Enrollment Agreement are material to Our administration of the Agreement. During the term of the Agreement, We will not permit any change in these eligibility requirements unless We agree, in writing, to such change.

V. NOTICE:

All notice to be given to the Group will be addressed to:

Entwistle & Cappucci LLP
280 Park Avenue
New York, NY 10017
Attn: Stella Ivanova

All notices to be given to the Group Broker will be addressed to:

Michaels Norman J & Associates Inc.
80 Business Park Dr.
Suite 306
Armonk, NY 10504
Attn: Michele L. Gasparee

All notices to be given to Us will be addressed to:
Oxford Health Insurance, Inc.

10 Tara Boulevard
Nashua, NH 03062

6104104520

VI. PREMIUM DUE DATE AND PAYMENTS:

The first day of the month is the "Premium Due Date." The Group agrees to remit to Us on or before the Premium Due Date the applicable Total Monthly Premium set forth in Section III above for each Member enrolled as of such date. Membership as of such date will be determined by Us in accordance with Our Member records. If a Premium payment is not made in full by Group on or prior to the Premium Due Date, a 30-day Grace Period will be granted to the Group for payment without interest charge. If payment is not received by the expiration of the Grace Period, then the Agreement may be terminated by Us pursuant to Section XIII of this document. Premiums outstanding subsequent to the end of the Grace Period will be subject to a late penalty charge of 1.50% of the total Premium amount due. This amount will be calculated for each 30-day period, or portion thereof, that the amount due remains outstanding. If the Agreement is terminated for any reason, the Group will continue to be held liable for all Premium payments due and unpaid before the termination, including, but not limited to, Premium payments for any time the Agreement is in force during the Grace Period.

Notwithstanding any language to the contrary in the Agreement, We will have no obligation to provide benefits or pay claims for any Member during any period for which the required Premium payment has not been made, including during any Grace Period. If We provide benefits or pay claims for any Member during any period for which the Premium payment has not been made, such provision of benefits or payment of claims will not constitute a waiver of Our right to discontinue the provision of coverage or payment of claims until such time as the Premium payment is made.

VII. PREMIUM ADJUSTMENTS:

A. Enrollment. If a Member enrolls on or before the fifteenth (15th) day of a month, the Group will remit to Us on or before the next Premium Due Date an additional Total Monthly Premium for such Member for the month in which the Member enrolled. If a Member enrolls after the fifteenth (15th) day of a month, no additional Premium payment will be due for such Member for the month in which the Member enrolled. Note: This does not apply to any Group where the Subscribers become eligible for coverage on the first day of the month, per Section IV, "Eligibility."

B. Termination. If a Member's coverage ends on or before the fifteenth (15th) day of a month, We will credit the Group the total Monthly Premium for such Member for that month. If a Member's coverage ends after the fifteenth (15th) day of a month, the Group will not be entitled to any Premium adjustment from Us. Note: This does not apply to any Group whose Subscriber's lose coverage on the last day of the month, per Section IV, "Eligibility."

VIII. PREMIUM RATE CHANGES:

Initial Contract Period: The Premium Rate Schedule set forth on page one of this Group Enrollment Agreement will be valid only for the Initial Contract Period. Premium Rates for the Initial Contract Period will not be changed by Us unless a change required by statute or regulation increases Our cost risk under the Agreement. If such a statutory or regulatory change occurs, We may change the Premium Rate Schedule at any time with a 45-day prior written notice to Group.

Subsequent Contract Period: At any time, with a 45-day prior written notice, We may change the Premium Rate Schedule for any Subsequent Contract Period as follows:

· Upon the renewal of the Agreement; and

· When a change required by statute or regulation that increases Our risk under the Agreement.

We may also change the Premium Rate for any other reason upon a 90-day prior written notice to the Group.

Regarding renewals: If We fail to give the Group the required advance notice, the Premium Rates in effect prior to the commencement of the Subsequent Contract Period will remain in effect for a period of 45 days after the Group was notified by Us of the new Premium Rates for the Subsequent Contract Period, after which period the new Premium Rates will go into effect.

Any change in the Premium Rates will be subject to the approval of the New York Insurance Department

IX. MEMBER EFFECTIVE DATES OF COVERAGE:

Coverage of prospective Members will be subject to Our receipt of an Enrollment Form and applicable monthly Premium for each prospective Member within 31 days of the Member becoming eligible for coverage under the Agreement.

X. INELIGIBLE MEMBERS:

If the Group fails to immediately notify Us of a Member's ineligibility, and the Group has made or continues to make the Premium payments for such Member, We will credit such Premium payment back to the last day of the month immediately prior to the month in which such termination notice is received by Us. We will provide this credit only if We have not authorized or incurred claims for health services for such Member during the period when We were unaware of the Member's ineligibility.

XI. OPEN ENROLLMENT PERIOD:

The Group will hold a Group Open Enrollment Period at least once each year. During the Group Open Enrollment Period, eligible employees, as determined by the Agreement, may elect coverage under the Agreement.

XII. RESPONSIBILITIES OF GROUP:

Group agrees to:

A. Offer coverage to eligible employees and their eligible family members, as described in Section IV above. It is agreed that eligible employees of the Group will be free to choose Our coverage or any other coverage as may be available through the Group during the initial and subsequent Group Open Enrollment Periods. Every eligible employee of the Group will be given a fair opportunity to elect one of the Group's coverage options and will not be penalized by the Group because of his or her choice.

B. Offer each new employee the opportunity to elect Our coverage as a procedure of employment when he or she becomes an eligible employee as described in the Agreement.

C. Provide notification to each Member, within 15 days after termination of the Member's coverage, of the Member's right to convert to one of Our individual direct payment contracts, contingent upon the Member having reasonable access to Our Service Area.

6104104522

D. Furnish to Us, on a monthly basis (or as otherwise required), on Our approved forms, such information as may reasonably be required by Us for the administration of the Agreement, including any change in a Member's eligibility status. In addition, We may, at reasonable times, examine the Group's pertinent records with respect to eligibility and Premium payments hereunder.

E. Comply with all policies and procedures established by Us in administering and interpreting the Agreement.

XIII. TERMINATION:

A. The Agreement may be terminated by Us:

(i) Upon written notice, if any Premium payment or contribution required to be made by the Group is not received by the Premium Due Date, subject to a 30-day grace period;

(ii) Upon written notice, if the Group ceases to operate or relocates outside of the Service Area;

(iii) If the Group has performed an act or practice that constitutes fraud or made an intentional misrepresentation of material fact under the terms of the Agreement;

(iv) We cease offering group contracts in New York in accordance with applicable law;

(v) The Group ceases to meet the requirements for a group as defined under applicable law or fails to meet participation requirements;

(vi) In connection with this Plan, there is no longer any employee or dependent who lives, resides or works in the Service Area; or

(vii) For such other reasons as are acceptable to the Superintendent of Insurance and not inconsistent with Public Law 104-191.

B. The Agreement may be terminated by the Group:

(i) Upon written notice, in the event of the insolvency or bankruptcy of OHI;

(ii) Upon written notice, in the event of the revocation of OHI's license;

(iii) In the event of Our material breach of any of the terms and provisions of the Agreement, upon a 45-day prior written notice to Us;

(iv) As of the date any Premium change would become effective, by providing Us with written notice of termination not less than 30 days prior to such effective date; or

(v) Without cause, by giving Us a 60-day advance written notice.

XIV. ENTIRE AGREEMENT:

6104104523

The Agreement constitutes the entire agreement between the parties and supersedes all prior and contemporaneous arrangements, understandings, negotiations and discussions of the parties with respect to the subject matter hereof, whether written or oral; and there are no warrantees, representations, or other agreements between the parties in connection with the subject matter hereof, except as specifically set forth herein. No supplement, modification or waiver of the Agreement will be binding unless executed in writing by authorized representatives of the parties.

XV. APPLICABLE LAW:

The Agreement will be governed by the laws of the State of New York.

XVI. INCONSISTENCY:

In the event of any inconsistency between this Group Enrollment Agreement and the Certificate, the terms of this Group Enrollment Agreement will govern.

XVII. AMENDMENTS:

Any amendments to the Agreement must be in writing and must be approved by authorized representatives of both the Group and OHI. No other individual has the authority to modify the Agreement, waive any of its provisions or restrictions, extend the time for making a payment, or bind OHI by making any other commitment or representation.

Formal acceptance of an amendment to the Agreement by the Group will not be required if: the change has been negotiated by means of a request by the Group and agreed to by Us and such amendment is attached to this Group Enrollment Agreement; if the change is required to bring the Agreement into conformance with any applicable law, regulation or ruling of the jurisdiction in which the Agreement is delivered or of the federal government; or if the Group makes payment of any applicable Premium on and after the effective date of such amendment.

OXFORD HEALTH PLANS (NY), INC.

By: _____
Authorized Signature

Title: _____

Date: APR 13 2006

Entwistle & Cappucci LLP
(Group)

By: _____
Authorized Signature

Title: Managing Partner

Date: 2/21/06

EXHIBIT K

OXFORD HEALTH PLANS®

A UnitedHealthcare Company

602020 1781

Please do not write in this area, for Oxford use only.

New York Member Enrollment Form - OHI

Mailing Address: P.O. Box 7085, Bridgeport, CT 06601 • www.oxfordhealth.com

To Be Completed By EMPLOYER (Please Print)

NAME OF GROUP (EMPLOYER)	GROUP NUMBER	CONTRACT SPECIFIC PACKAGE (CSP)	BILLING GROUP (BG)
ENTWISTLE + CAPPUCCI LLP			

EMPLOYEE'S EFFECTIVE DATE OF COVERAGE	IS INDIVIDUAL COVERED UNDER COBRA? IF YES, QUALIFYING EVENT	DATE OF QUALIFYING EVENT
MO. 2 DAY 10 YEAR 06	☐ YES ☒ NO	MO. DAY YEAR

DATE OF FULL-TIME EMPLOYMENT	AVERAGE NO. OF HOURS WORKED PER WEEK	EMPLOYEE OCCUPATION: ☐ EXECUTIVE ☐ MANAGEMENT ☒ NON-MANAGEMENT ☐ HOURLY ☐ OTHER (PLEASE SPECIFY)	EMPLOYEE CLASSIFICATION
MO. 02 DAY YEAR 02	40		☐ UNION ☒ NON-UNION

X EMPLOYER SIGNATURE — DATE 11/10/06

To Be Completed By EMPLOYEE (Please Print)

SOCIAL SECURITY NO. [redacted]

FIRST NAME Stephen — MI D — BIRTH DATE MO. 8 DAY 5 YEAR 43 — ☒ MALE ☐ FEMALE — HOME PHONE (212) 427-2299 — BUSINESS PHONE (212) 894-7200

STREET ADDRESS 1060 Fifth Ave — APT. NO. — CITY New York — STATE NY — ZIP 10028

WILL YOU HAVE ANY OTHER HEALTH COVERAGE (INCLUDING MEDICARE) WHILE ENROLLED WITH OXFORD? ☐ YES ☐ NO IF YES, CARRIER NAME — NAME OF POLICY HOLDER — POLICY START DATE / /

OXFORD CODE OF PRIMARY CARE PHYSICIAN SELECTED Dr Vogel - NYC — ARE YOU AN EXISTING PATIENT? ☒ YES ☐ NO — PRIOR HEALTH INSURANCE INFORMATION: CARRIER NAME

OXFORD CODE OF OB/GYN SELECTED (Female Members) — ARE YOU AN EXISTING PATIENT? ☐ YES ☐ NO — COVERAGE BEGIN DATE / / COVERAGE END DATE / /

EMPLOYEE'S Dependent Information Please only complete for dependents who will be covered on your Oxford policy (Please Print)

SPOUSE'S SOCIAL SECURITY NUMBER — SPOUSE'S LAST NAME — SPOUSE'S FIRST NAME — MI

SPOUSE'S BIRTH DATE MO. DAY YEAR — ☐ MALE ☐ FEMALE — DATE OF MARRIAGE MO. DAY YEAR — SPOUSE'S EMPLOYER

WILL YOU HAVE ANY OTHER HEALTH COVERAGE (INCLUDING MEDICARE) WHILE ENROLLED WITH OXFORD? ☐ YES ☐ NO IF YES, CARRIER NAME — NAME OF POLICY HOLDER — POLICY START DATE / /

OXFORD CODE OF PRIMARY CARE PHYSICIAN SELECTED — ARE YOU AN EXISTING PATIENT? ☐ YES ☐ NO — PRIOR HEALTH INSURANCE INFORMATION: CARRIER NAME

OXFORD CODE OF OB/GYN SELECTED (Female Members) — ARE YOU AN EXISTING PATIENT? ☐ YES ☐ NO — COVERAGE BEGIN DATE / / COVERAGE END DATE / /

ELIGIBLE CHILD'S SOCIAL SECURITY NO. 10767 — ELIGIBLE CHILD'S LAST NAME [redacted] — ELIGIBLE CHILD'S FIRST NAME [redacted] — MI S — ☐ MALE ☐ FEMALE

ELIGIBLE CHILD'S BIRTH DATE MO. DA YEAR 87 — IS THIS DEPENDENT DISABLED? ☐ YES ☒ NO — WILL YOU HAVE ANY OTHER HEALTH COVERAGE (INCLUDING MEDICARE) WHILE ENROLLED WITH OXFORD? ☐ NO ☐ YES IF YES, CARRIER NAME: — NAME OF POLICY HOLDER — POLICY START DATE / /

OXFORD CODE OF PRIMARY CARE PHYSICIAN SELECTED — ARE YOU AN EXISTING PATIENT? ☐ YES ☐ NO — PRIOR HEALTH INSURANCE INFORMATION: CARRIER NAME

OXFORD CODE OF OB/GYN SELECTED (Female Members) — ARE YOU AN EXISTING PATIENT? ☐ YES ☐ NO — COVERAGE BEGIN DATE / / COVERAGE END DATE / /

ELIGIBLE CHILD'S SOCIAL SECURITY NO. [redacted] — ELIGIBLE CHILD'S LAST NAME [redacted] — ELIGIBLE CHILD'S FIRST NAME Sarah — MI M — ☐ MALE ☐ FEMALE

ELIGIBLE CHILD'S BIRTH DATE MO. DAY YEAR — IS THIS DEPENDENT DISABLED? ☐ YES ☒ NO — WILL YOU HAVE ANY OTHER HEALTH COVERAGE (INCLUDING MEDICARE) WHILE ENROLLED WITH OXFORD? ☐ NO ☐ YES IF YES, CARRIER NAME: — NAME OF POLICY HOLDER — POLICY START DATE / /

OXFORD CODE OF PRIMARY CARE PHYSICIAN SELECTED — ARE YOU AN EXISTING PATIENT? ☐ YES ☐ NO — PRIOR HEALTH INSURANCE INFORMATION: CARRIER NAME

OXFORD CODE OF OB/GYN SELECTED (Female Members) — ARE YOU AN EXISTING PATIENT? ☐ YES ☐ NO — COVERAGE BEGIN DATE / / COVERAGE END DATE / /

ELIGIBLE CHILD'S SOCIAL SECURITY NO. — ELIGIBLE CHILD'S LAST NAME — ELIGIBLE CHILD'S FIRST NAME — MI — ☐ MALE ☐ FEMALE

ELIGIBLE CHILD'S BIRTH DATE MO. DAY YEAR — IS THIS DEPENDENT DISABLED? ☐ YES ☐ NO — WILL YOU HAVE ANY OTHER HEALTH COVERAGE (INCLUDING MEDICARE) WHILE ENROLLED WITH OXFORD? ☐ NO ☐ YES IF YES, CARRIER NAME: — NAME OF POLICY HOLDER — POLICY START DATE / /

OXFORD CODE OF PRIMARY CARE PHYSICIAN SELECTED — ARE YOU AN EXISTING PATIENT? ☐ YES ☐ NO — PRIOR HEALTH INSURANCE INFORMATION: CARRIER NAME

OXFORD CODE OF OB/GYN SELECTED (Female Members) — ARE YOU AN EXISTING PATIENT? ☐ YES ☐ NO — COVERAGE BEGIN DATE / / COVERAGE END DATE / /

If you have additional dependents, please use another enrollment form to provide the necessary information.
In order to help us quickly process this form and avoid delays, please make sure all areas are properly filled out.

I understand that my enrollments and benefits are in accordance with those described in the Oxford Health Insurance Certificate. I understand that, in order to receive in-network benefits, I and any enrolled dependents must seek care through our Oxford affiliated primary care physician or through an Oxford-affiliated specialist physician with an authorized referral from the primary care physician if required. I further understand that if I do not adhere to these requirements, I will be eligible only for out-of-network health insurance coverage under the terms of the Certificate.

Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information, or conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime and shall also be subject to a civil penalty not to exceed five thousand dollars and the stated value of the claim for each such violation.

X [redacted] — DATE 11/10/06

EMPLOYEE/APPLICANT SIGNATURE

Exhibit L

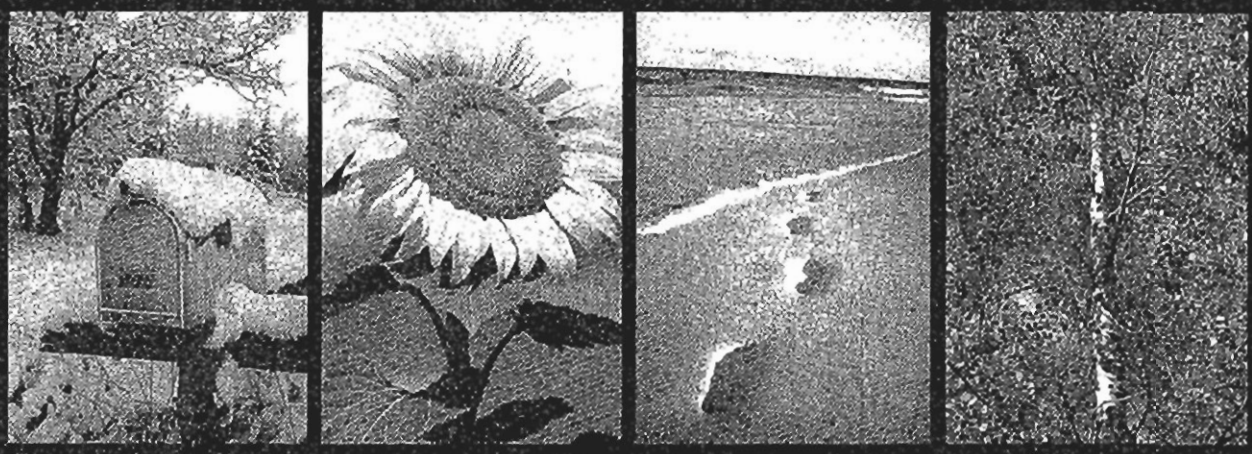
Pursuant to Rule 5 of the United States District Court for the Southern District of New York Procedures For Electronic Case Filing only excerpts of the referenced document have been electronically filed due to the volume of the exhibit.

(This exhibit has been Bates Stamped and a complete copy is being served on plaintiff.).

This filing is without prejudice to any parties' right to supplement the exhibit or file the complete document.

2/1/06

Your Oxford Coverage for all seasons



OXFORD HEALTH PLANS®

A UnitedHealthcare Company

EC1227_CSP02

REDACTED
NEW YORK, NY 10028

FREEDOM PLAN CLASSIC

OXFORD
HEALTH PLANS®
A UnitedHealthcare Company

14Feb2008
5427 (07/05)

2006 CERT 002

OXFORD
HEALTH PLANS®
A UnitedHealthcare Company

Dear Oxford Member,

Welcome, and thank you for selecting Oxford Health Plans.

At Oxford, your satisfaction is important to us, and we strive to help make your healthcare experience a positive one. As an Oxford Member, you have access to a series of programs and resources to help you along your road to health:

- A robust network of hospitals and providers from a local health plan with over 20 years of experience. If your employer's plan offers out-of-area coverage, you also have in-network national access outside of Oxford's tri-state service area through the UnitedHealthcare Choice Plus network.
- Our *Healthy Bonus*® program, which consists of special offers and discounts that help you stay healthy and manage special conditions. Members can save on services such as weight loss programs, fitness equipment and publications.
- Our web site, *www.oxfordhealth.com*, which allows you to conduct business (e.g., request an ID card, update or correct any personal information, etc.) and access health information at your convenience.
- Healthcare guidance 24 hours a day, seven days a week, from Oxford's registered nurses through *Oxford On-Call*®
- *Healthy Mind Healthy Body*® magazine, your source for health information on prevention, nutrition, and exercise, as well as important benefit and coverage information.

The following information is enclosed: your new Summary of Benefits, Certificate of Coverage and other important plan information. If you have questions about your coverage, or want to learn more about Oxford's programs and resources, please log on to *www.oxfordhealth.com* or call Customer Service at the number on your Oxford ID card.

Wishing you the best of health.

Sincerely,

Kevin Hill
Chief Executive Officer, Northeast Region

Enclosures

OXFORD HEALTH PLANS, INC.
FREEDOM CLASSIC PLAN
SUMMARY OF BENEFITS
Entwistle & Capucci LLP

Covered Services	In-Network	Out-of-Network
Primary and Preventive Care		
Physician Office and Home Visits	No Charge for Preventive Care	Adult Primary and Preventive Care is Covered subject to Deductible and 20% Coinsurance.
	Primary Care is Covered subject to a Copayment of $10 per visit	Primary and Preventive Care for Children is Covered subject to Deductible and 20% Coinsurance.
	Two well-woman examinations, two Pap tests and age appropriate mammograms per Calendar Year are Covered at No Charge.	Two well-woman examinations per Calendar Year, Pap tests and age appropriate mammograms are Covered subject to Deductible and 20% Coinsurance. **Some procedures require Precertification. Please see your Certificate.**
Inpatient Hospital Visits	No Charge	Covered subject to Deductible and 20% Coinsurance.
Diabetes Education and Self-Management	$10 per visit	Covered subject to Deductible and 20% Coinsurance.
Diabetic Supplies	Covered subject to a Copayment of $10 per 30-day supply of each item.	Covered subject to Deductible and 20% Coinsurance. **Precertification is required before the purchase of an insulin pump.**
Specialty Care		
Physician Office and Home Visits	$15 per visit	Covered subject to Deductible and 20% Coinsurance. **Some procedures require Precertification. Please see your Certificate.**
Inpatient Hospital Visits	No Charge	Covered subject to Deductible and 20% Coinsurance.
Obstetrical Services (including prenatal and postnatal)	$10 per initial visit.	Covered subject to Deductible and 20% Coinsurance. **Precertification is required.**

PLEASE REVIEW THE MAXIMUMS AND LIMITATIONS (pages 5 & 6)

Covered Services	In-Network	Out-of-Network
Elective Termination of Pregnancy	No Charge	Covered subject to Deductible and 20% Coinsurance.
Allergy Testing and Treatment	$15 per visit	Covered subject to Deductible and 20% Coinsurance.
Short-Term Rehabilitative Services (Physical, Speech and Occupational)		
Outpatient	$15 per visit	Covered subject to Deductible and 20% Coinsurance.
Inpatient	No Charge	Covered subject to Deductible and 20% Coinsurance. **Precertification is required.**
Oral Surgery		
Office Visit	$15 per visit	Covered subject to Deductible and 20% Coinsurance. **Precertification is required.**
Outpatient	No Charge	Covered subject to Deductible and 20% Coinsurance. **Precertification is required.**
Inpatient	No Charge	Covered subject to Deductible and 20% Coinsurance. **Precertification is required.**
Pediatric Preventive Dental (through age 11)	No Charge	No Charge
Laboratory Procedures and X-ray Examinations	No Charge	Covered subject to Deductible and 20% Coinsurance.
Facility Based Radiology Services (including but not limited to MRI, PET and CAT Scans)	No Charge	Covered subject to Deductible and 20% Coinsurance. **Precertification is required for PET Scans, MRA, and Surgical Endoscopic Procedures. Effective 4/1/05, MRIs, Nuclear Medicine, and CAT Scans will also require Precertification.**
Diagnostic Mammography	No Charge	Covered subject to Deductible and 20% Coinsurance.
Prosthetic Devices	No Charge for an internal prosthetic device.	No Charge for an internal prosthetic device.
	Inpatient Surgery is at No Charge.	Surgery is Covered subject to Deductible and 20% Coinsurance.
	Outpatient Surgery is Covered at No Charge.	
	External prosthetic devices are Covered at No Charge.	External Devices are Covered subject to Deductible and 20% Coinsurance. **Precertification is required before purchase.**

Covered Services	In-Network	Out-of-Network
Durable Medical Equipment	No Charge	Covered subject to Deductible and 20% Coinsurance. **Precertification is required on items that cost $500 or more.**
Medical Supplies	**No In-Network Benefit**	Covered subject to Deductible and 20% Coinsurance.
Transplants	Transplants performed at Our approved facilities are Covered at No Charge. Transplants performed at other Network facilities are Covered on an Out-of-Network basis.	Covered subject to Deductible and 20% Coinsurance. **Precertification is required.**
Home Health Care	$15 per visit	Covered subject to 20% Coinsurance. Not subject to Deductible. **Precertification is required.**
Chiropractic Services	$15 per visit	Covered subject to Deductible and 20% Coinsurance.
Second Opinions	At your request $15 per visit At Our Request, No Charge.	Covered subject to Deductible and 20% Coinsurance.
Hospital and Other Facility Based Services		
Inpatient Hospital Services	Covered at No Charge	Covered subject to Deductible and 20% Coinsurance. **Precertification is required.**
Outpatient Hospital Services and Ambulatory Surgical Center Services	Covered at No Charge	Covered subject to Deductible and 20% Coinsurance. **Precertification is required.**
Skilled Nursing Facility Services	Covered at No Charge	Covered subject to Deductible and 20% Coinsurance. **Precertification is required.**
Hospice Services		
Outpatient	Covered at No Charge	Covered subject to Deductible and 20% Coinsurance. **Precertification is required.**
Inpatient	Covered at No Charge	Covered subject to Deductible and 20% Coinsurance. **Precertification is required.**
Home Health Care	Covered subject to a Copayment of $15 per visit.	Covered subject to 20% Coinsurance. Not subject to Deductible. **Precertification is required.**
Skilled Nursing Facility Services	Covered at No Charge	Covered subject to Deductible and 20% Coinsurance. **Precertification is required.**

Covered Services	In-Network	Out-of-Network
Alcohol and Substance Abuse Services		
Outpatient Alcohol and Substance Abuse Rehabilitation	Covered at No Charge.	Covered subject to Deductible and 20% Coinsurance. **Precertification is required.**
Medical Emergency and Urgent Care Services		
Emergency Room Services	Covered subject to a Copayment of $50 per visit (Waived if Member becomes confined in a Hospital).	When proper notice is **not** given, Medical Emergency Admissions are Covered as described in the Certificate subject to Deductible and 50% Coinsurance.
Urgent Care Facility Services	When proper notice is given the services of Network and Non-Network Providers are Covered subject to a Copayment of $15 per visit.	When proper notice is **not** given, Covered subject to Deductible and 20% Coinsurance.
Ambulance Services	No Charge	No Charge
Supplemental Coverage		
Outpatient Prescription Drugs		Not Covered
	A Copayment of $7 per Generic Prescription and refill. A Copayment of $20 per each Preferred Brand Prescription and refill. A Copayment of $50 per each Non-Preferred Brand Name Prescription and refill.	
	All Copayments listed above apply to a 30-day supply of each prescribed drug. Mail Order Drugs: Copayments are the same as listed above except that you must pay 2 Copayments for a 90-day supply.	
Outpatient Mental Health Services	Covered subject to a Copayment of $15 per visit.	Covered subject to Deductible and 50% Coinsurance. **Precertification is required.**
Inpatient Mental Health Services	Covered at No Charge.	Not Covered.
Inpatient Substance Abuse Rehabilitation and Detoxification	Covered at No Charge	Covered subject to Deductible and 50% Coinsurance. **Precertification is required.**

Covered Services	In-Network	Out-Of-Network
Basic & Comprehensive Infertility Services & Advanced Infertility Services		
Outpatient	Covered at No Charge	Covered subject to Deductible and 20% Coinsurance. **Precertification is required. Advanced Services are Not Covered**
Inpatient	Covered at No Charge	Covered subject to Deductible and 20% Coinsurance. **Precertification is required. Advanced Services are Not Covered**
Office Visits	Covered subject to a Copayment of $15 per visit.	Covered subject to Deductible and 20% Coinsurance. **Advanced Services are Not Covered**
Prosthetic Repair and Replacement	No Charge	Covered subject to Deductible and 20% Coinsurance.

MAXIMUMS AND LIMITATIONS

Unless otherwise indicated, the following maximums and limitations apply to both the In-Network and Out-of-Network Benefits combined.

Important. Coverage In-Network does not duplicate coverage Out-of-Network. **Benefits are not cumulative.** Benefits received In-Network reduce the amount of benefits available Out-of-Network. Benefits received Out-of-Network reduce the amount of benefits available In-Network.

All reimbursements for Out-of-Network benefits are subject to UCR at the 90% percentile of HIAA.

Preventive Care for Adults	Out-of-Network benefit is limited to $300.
Preventive Care for Children	Out-of-Network benefit is limited to $300.
Diabetic Supplies	Diabetic supplies will only be supplied in amounts consistent with the Member's treatment plan as developed by the Member's Physician. Only basic models of Blood glucose monitors are Covered unless the Member has special needs relating to poor vision or blindness.
Elective Termination of Pregnancy	We Cover one procedure per Member per Contract Year. We pay a maximum benefit of $350 per procedure.

Short-Term Rehabilitation Therapy Services (Physical, Speech, Occupational)	
Outpatient	90 visits per condition, per lifetime.
Inpatient	One consecutive 60-day period per condition, per lifetime.
Durable Medical Equipment	We will pay a maximum benefit of $1500 per Member, per Calendar Year.
Transplants	**In-Network Coverage is available only at Network facilities specifically approved and designated by Us to perform these procedures.** Transplants performed at any other Network facility will be eligible for coverage only at the Out-of-Network level of coverage.
Exercise Facility Reimbursement	Within one 6-month period We will reimburse you $200. We will reimburse your spouse $100 per 6-month period. The member must complete 50 visits within the 6-month period.
Skilled Nursing Facility Services	30 days per Calendar Year.
Hospice Services	210 days
Bereavement Counseling for Member's Family	5 sessions either before or after the death of the Member.
Outpatient Alcoholism and Substance Abuse Rehabilitation	60 visits per Calendar Year. Up to 20 of these visits may be used by the Member's family when the Member is in active treatment.
Supplemental Coverage Information	
Outpatient Mental Health Services	30 visits per Calendar Year
Inpatient Mental Health Services	30 days per Calendar Year
Inpatient Alcohol and Substance Abuse Rehabilitation	30 days per Calendar Year
Detoxification	7 days per Calendar Year
Infertility Treatment	**This benefit is limited to Network Providers.** Advanced Infertility Services are limited to $10,000 per Member, per lifetime.

FAILURE TO PRECERTIFY

If you fail to obtain a required Precertification for an Out-of-Network benefit, you will be subject to a reduction in benefits. You must pay 50% of the costs for such service or supply.

DEDUCTIBLES

The applicable Deductibles for this Plan are:

Out-of-Network	Individual: $3000 Family - A maximum of 2.5 times the Individual Deductible.

OUT-OF-POCKET MAXIMUM

Out-of-Network

The maximum amount you must pay in any Calendar Year for Out-of-Network Covered Services is $5000 for an individual and 2.5 times per family.

Remember, only Out-of-Network Coinsurance and the amounts paid to meet your Out-of-Network Deductible count toward the Out-of-Network, Out-of-Pocket Maximum. Copayments and/or Deductible and Coinsurance for In-Network benefits, amounts in excess of the UCR, amounts paid for non-Covered Services, and any amounts paid as a penalty do not count toward the Out-of-Network, Out-of-Pocket Maximum.

Coinsurance paid for any Covered Service obtained under Supplemental Coverage (excluding State mandated offers) will not be applied toward the Out-of-Pocket Maximums. Therefore, amounts paid for: outpatient prescription drugs, vision care or dental care if purchased by group, will not be applied toward either Out-of-Pocket Maximum.

ELIGIBILITY LIMITS

The limiting ages for dependents (as defined in the Certificate) are: under the age of 19 and between the ages of 19 and 23 for a full-time student. Coverage ends at the end of the Calendar Year.

EFFECTIVE DATES OF COVERAGE

Initial Enrollment (During the initial Group Open Enrollment Period). Coverage is effective on the effective date of the Agreement.

Newly Eligible Employee (Application within 31 days of becoming eligible). Coverage is effective as of the date the employee became eligible.

Newly Eligible Dependents (Application within 31 days of becoming eligible). Coverage is effective as of the date the dependent became eligible.

Group Open Enrollment Period. Coverage will be effective on the renewal date of the Agreement.

IMPORTANT: this document is not a contract. It is only a summary of your coverage under the Freedom Classic Plan. Please read your Certificate for a full description of your Covered Services, exclusions and other terms and conditions of coverage.

OXFORD
HEALTH PLANS®
A UnitedHealthcare Company

NY Large Classic Plan

Certificate of Coverage
&
Member Handbook

Cover Sheet

CERTIFICATE OF COVERAGE ("Certificate")
for
OXFORD HEALTH INSURANCE, INC. ("Oxford")

Please read this entire Certificate carefully, including your Summary of Benefits which contains information specific to your Group. These documents, and any attached riders, describe your rights and obligations and those of Oxford.

Under this Certificate, you engage Oxford to make arrangements through which medical and hospital services will be delivered in accordance with the terms and conditions of this Certificate and in reliance upon the statements you made in your application for coverage. Oxford agrees with the Group to provide the Covered Services set forth in this Certificate, as may be amended from time to time by Oxford or the Group's Board of Directors or similar body. Please note:

- This Certificate and any riders, schedules or attachments have been delivered in consideration of the Group's timely payment of Premiums.
- No services are Covered under this Certificate in the absence of current payment of Premiums, subject to a 30-day Grace Period and the terms and conditions of the Certificate.
- No services are Covered under this Certificate unless your coverage is in force at the time you receive services.
- In some instances a medical procedure may not be Covered or may require Precertification. It is your responsibility to understand the terms and conditions in this Certificate.
- This Certificate replaces any older Certificate issued to you which provided coverage under the Plan.
- This Certificate is not in lieu of and does not affect any requirements for coverage by Workers' Compensation Insurance.

This Certificate is governed by the laws of the State of New York.

Please Note: Unless otherwise expressly indicated in this Certificate, coverage will cease upon the termination of this Certificate. Benefit changes are effective on the renewal date of this Certificate. Benefits do not vest.

Section VI.
Exclusions and Limitations

(**IMPORTANT:** Neither the list of Covered Services nor the list of Exclusion and Limitations is exhaustive. Due to the ever changing availability of new medical technology, it is impossible to list every Covered Service or exclusion. If you cannot determine whether or not a specific services will be Covered, please call Us. Do not Assume that the service is Covered; there may be no coverage available.)

Unless coverage is specifically provided under this Certificate or provided under a rider or attachment to this Certificate, the following services and benefits are **not** Covered.

1. Services which We have determined are not Medically Necessary. If there is a dispute between a Provider and Us about the Medical Necessity of a service or supply, you or your Physician may appeal Our decision. Any disputed service or supply will not be Covered during the appeal process (please refer to the "Utilization Review Appeal" provision of this Certificate).

In no event will We seek reimbursement from a Member for the cost of any Covered Service provided under this Certificate that We determine is not Medically Necessary when such service was rendered by the Member's PCP or upon referral of the PCP

2. Fifty percent of the benefits normally payable for Covered Services for which a required Precertification was not obtained.

3. Unless added to this Certificate as described under "Supplemental Coverage," Acupuncture therapy.

4. Unless added to this Certificate as described under "Supplemental Coverage," Alcohol and Substance Abuse Services on an inpatient basis and detoxification are not Covered.

5. An adopted newly born infant's initial hospital stay if the natural parent has coverage available for the infant's care.

6. Birth control pills and implantable contraceptive drugs are excluded unless Supplemental Coverage for Outpatient Prescription Drugs (that includes these items) is purchased by the Group. Over-the-counter items such as condoms, foams or devices, contraceptive jellies and ointments are not Covered.

7. Care for conditions that by federal, state or local law must be treated in a public facility including, but not limited to, commitments for mental illness. Additionally, to the extent allowed by law, we do not Cover care or treatment provided in a Hospital that is owned or operated by any federal, state or other governmental entity.

8. Comfort or convenience items including, but not limited to: barber services; guest meals and accommodations; telephone, television or radio charges; travel expenses; or take-home supplies. We also do not Cover the purchase or rental of household fixtures or equipment including, but not limited to: escalators; elevators; swimming pools; exercise cycles; air purifiers; air conditioners; water purifiers; allergenic pillows, mattresses or waterbeds.

9. Cosmetic surgery, plastic or reconstructive surgery which is performed primarily to improve the appearance of any portion of the body including but not limited to: surgery for sagging of extra skin; any augmentation or reduction procedure (e.g., mammoplasty); liposuction; keloids; rhinoplasty and associated surgery. Complications of such surgeries are Covered only if they are Medically Necessary and are otherwise Covered. Remedial work is not Covered.

10. Court ordered services or services that have been ordered as a condition of probation or parole. However, these services may be Covered if We agree that the services are Medically Necessary, are otherwise Covered, the Member has not exhausted their benefit for the Calendar Year, and the treatment is provided in accordance with our policies and procedures.

11. Custodial care, domiciliary care, long-term care, maintenance care, adult day care or rest cures. We do not Cover room, board, nursing care or personal care which is rendered to assist a Member who, in Our opinion, has reached the maximum level of physical or mental function possible and will not make further significant clinical improvement.

12. Dental services related to the care, filling, removal or replacement of teeth and the treatment of injuries or diseases of the teeth, gums and temporomandibular joint, including, but not limited to: apicoectomy, orthodontics, root canals, soft tissue impaction, temporomandibular joint dysfunction therapy, alveolectomy, treatment of periodontal disease or orthognathic surgery. As described in Section IV, 2, F, "Oral Surgery," only dental services required to treat accidental injury of sound, natural teeth are Covered.

13. Diabetic services or supplies as follows. The following are not Covered as diabetic services or supplies: services or supplies that are not both Medically Necessary and prescribed by the Member's Physician or qualified health professional; membership in health clubs, diet clubs or plans for the purpose of losing weight even if recommended by the Member's Physician or qualified health professional; any counseling or courses in diabetes management other than as described as Covered under this Certificate; stays at special facilities or spas for the purpose of diabetes education or management; and special foods, diets aids and supplements related to dieting;

14. Durable Medical Equipment: We do not Cover: orthotics, arch supports, corrective shoes, false teeth, and hearing aids.

15. Experimental, investigational or ineffective; surgical or medical treatments, procedures, drugs, or research studies including, but not limited to: transplants, stem cell retrieval, cancer chemotherapy protocols, AIDS clinical trials or I.V. therapies that are not recognized as acceptable medical practice and any such services where federal or other governmental agency approval is

required but has not been granted. We will make the determination as to whether the requested service is excluded in accordance with this provision. In certain instances, such procedures may be Covered if they are approved in advance by one of Our Medical Directors and provided in accordance with the provisions of this Certificate.

Important: In general, We will not Cover experimental or investigational treatments. However, We shall Cover an experimental or investigational treatment approved by an External Appeal Agent certified by the State. If an External Appeal Agent approves coverage of an experimental or investigational treatment that is part of a clinical trial, We will only Cover the cost of services required to provide treatment to you according to the design of the trial. We shall not be responsible for the costs of investigational drugs or devices, the costs of non-health care services, the costs of managing research, or costs which would not be Covered under this Certificate for non-experimental or non-investigational treatments provided in such clinical trail.

We will Cover autologous bone marrow transplants combined with high dose chemotherapy when **medically appropriate**, for the treatment of: advanced neuroblastoma, second remission acute leukemia, relapsed Hodgkin's disease, relapsed non-Hodgkin's lymphoma, and metastatic breast cancer or any other diagnosis that Our Medical Advisory Board determines to be appropriate. We will make the determination of when such treatment is **medically appropriate**. Such treatment must be approved in advance by one of Our Medical Directors and provided in accordance with the provisions of this Certificate.

16. Improper use of an emergency room or emergency admissions. Routine care and treatment for conditions that We determine were not Medical Emergencies, when received in an emergency room, are not Covered. If you are not certain whether the services you received are Covered, please submit them to Us for review.

17. Infertility treatment and supplies when used either to treat infertility or any other condition not Covered under this Certificate (e.g., genetic selection). The following, but not limited to, services and supplies are not Covered: injectable infertility drugs such as Pergonal, Metrodin etc., cost for an ovum donor or donor sperm, embryo or ovum transfer procedures, artificial insemination, sperm storage costs, cryopreservation and storage of embryos, ovulation predictor kits, in vitro services, in vivo fertilization, and all costs for and relating to surrogate motherhood (maternity services are Covered for Members acting as surrogate mothers). We also do not Cover services to reverse voluntary sterilizations. Treatment of an underlying medical condition will not be denied (if the treatment is otherwise Covered under the Certificate) solely because the medical condition results in infertility.

18. Learning and behavioral disorders. Services for the evaluation or treatment (including remedial education) of: learning disabilities or minimal brain dysfunction; mental retardation; developmental and learning disorders or behavioral problems. We also do not Cover behavioral training or cognitive rehabilitation.

19. Unless added to this Certificate as described under "Supplemental Coverage," Mental Health Services are not Covered.

20. When Medicare is the primary payor, We Cover the Services provided by this Certificate only to the extent they are not Covered under Medicare. Please see Section XII, "General Administrative Policies and Procedures," subsection, "Medicare and Other Government Programs."22. Services and treatment provided in a government facility.

21. Services and treatment provided in a government facility.

22. No-fault automobile insurance. Any Covered Services that are payable as personal injury benefits under mandatory no-fault automobile insurance. Where permitted by state law, any Covered Services which are eligible for payment under the provisions of an automobile insurance contract or pursuant to any federal or state law which mandates indemnification for such services to persons suffering bodily injury from motor vehicle accidents.

23. Non-eligible institutions. Any services or supplies furnished by a non-eligible institution, which is defined as other than a Hospital or Skilled Nursing Facility, and which is primarily a place of rest, a place for the aged, or any similar institution, regardless of how denominated.

24. Non-medical services and long-term rehabilitation services for physical therapy or the treatment of alcoholism or drug abuse, including rehabilitation services in a specialized inpatient or residential facility, except as specifically Covered under this Certificate.

25. No-show charges. If a Provider charges a fee for a missed appointment, you will be responsible for the payment of the fee.

26. Occupational conditions, ailments, or injuries arising out of and in the course of employment. Such conditions, ailments or injuries are not Covered if they are subject to coverage, in whole or in part, under any workers' compensation, occupational disease or similar law. This applies even if the Member's rights have been waived or qualified.

27. Unless added to this Certificate as described under "Supplemental Coverage," Outpatient prescription drugs are not Covered. Over-the-counter medications, drugs and devices are also excluded.

28. Private or special duty nursing.

29. Rehabilitation services or physical therapy on a long-term basis. Speech or occupational therapy to correct a condition that is not the result of a disease, injury or a congenital defect for which surgery has been performed.

30. Routine foot care including nail trimming, corn and callous removal, cleaning, soaking or any other hygienic maintenance or care.

- Patient name
- Type of service
- Name and address of provider making the charge
- CPT-4 codes, or HCPCS codes (description of services)
- Date of service
- Individual charge for each service
- ICD-9 codes (diagnosis or symptoms)

Be sure to keep a copy of your claim form and bills for your own records.

Claim forms are available from the Group or from Us by calling the Member Services telephone number listed in the front of this Certificate. Completed forms should be sent to the address listed for "Claims" at the front of this Certificate.

2. Payment options

You may request Us to make payment directly to you or to the provider. If you want Us to pay the provider directly (referred to as assignment), you must give the provider a blank claim form to be completed and forwarded with the itemized bill.

If you decide to pay a provider directly, submit the completed claim form with your bill to Us for reimbursement as described above. Although We will generally follow your instructions, We reserve the right to make the final determination.

3. Limitations

All requests for reimbursement must be made within 90 days of the date Covered Services were rendered. Failure to request reimbursement within the required time will not invalidate or reduce any claim if it was not reasonably possible to provide such proof within the 90-day period. However, such request must be made as soon as reasonably possible thereafter.

All reimbursements to non-Network Providers are subject to UCR unless you were referred to a non-Network Provider by your PCP or Us.

4. If You Receive a Bill from a Network Provider

The cost of Covered Services provided by Network Providers in accordance with the terms of this Certificate will be billed directly to Us. **No claim forms are necessary.**

If you should receive a bill from a Network Provider for Covered Services, please contact the Member Service Department immediately.

5. Claim Information

Claims for Covered Services will be paid within 45 days after We receive proof of claim and all of the information we need to process the claim. If necessary, Our Claims Department will contact you for more information regarding your claim in order to speed up the processing. If you would like to inquire about the status of a claim, call the "Claims" telephone number list in the front of this Certificate. Please have the date of service and your ID number ready.

6. Physical Examination

We have the right and the opportunity to examine the Member who is the basis of any claim at all reasonable times while the claim is pending. This will be done at Our expense.

Section XI.
Other Important Documents

1. Supplemental Coverage by Rider

The terms and conditions of this Certificate are subject to revision, addition or deletion. Any such changes will be made by rider. The terms of a rider that is issued by Us and accepted by the Group will supersede conflicting terms in this Certificate. Riders that are part of your Plan will be issued with your Certificate. However, you may want to verify with the Group whether your Plan is subject to any rider.

Please check with your Benefits Administrator to make sure you have the most recent documents concerning your supplemental coverage under the Plan.

2. Summary of Benefits

In order to receive Covered Services under this Certificate, We may require that you pay a Copayment or Coinsurance to the Provider who supplied the Covered Services. In addition, certain other charges may be applied. You will receive a Summary of Benefits that will explain all of the applicable Copayments and Coinsurance as well as other similar features of your Plan. It will also list specific limitations on visits, days and dollar amounts for the benefits that are provided by the Plan.

Please check with your Benefits Administrator to make sure you have the most recent Summary of your coverage under the Plan.

3. Living Wills and Advance Directives

You have the right to participate in decisions relating to your health care. Working with your doctor, you can decide whether to accept or reject proposed medical treatments. That right extends to situations where, because of your medical condition, you are unable to communicate with your doctor or the hospital. This is done by the creation of an Advance Directive.

An Advance Directive is a written, signed document, that provides instructions for your care if you are unable to communicate your wishes directly. Depending on the state where you reside or are

If a Member enters into litigation or settlement negotiations regarding the obligations of other parties, the Member must not prejudice, in any way, Our subrogation rights under this section.

In the event that you suffer an injury or illness for which another party may be responsible, such as someone injuring you in an accident, and We pay benefits as a result of that injury or illness, We will be subrogated and succeed to the right of recovery against the party responsible for your illness or injury to the extent of the benefits We have paid. This means that We have the right independently of you to proceed against the party responsible for your injury or illness to recover the benefits We have paid.

The costs of Our legal representation in matters related to subrogation shall be borne solely by Us. The costs of legal representation of the Member shall be borne solely by the Member.

5. Worker's Compensation

Injuries and diseases covered under any Worker's Compensation program are excluded from coverage under this Plan.

6. Medicare and Other Government Programs

This Plan is not intended to duplicate any coverage for which Members are, or could be eligible for, such as Medicare or any other federal or state government programs. Any benefits payable under any such programs for Covered Services provided or benefits paid under this Certificate shall be payable to and retained by Us. You agree to complete and submit to Us any documentation reasonably necessary for Us to receive or assure reimbursement under Medicare or any other government programs for which you or your Covered Dependents are eligible.

Benefits for Medicare Eligibles Who are Covered Under this Certificate

1. If your Group has 20 or more employees, any active employee or spouse of an employee who becomes or remains a member of the Group Covered by this Certificate, after becoming eligible for Medicare due to reaching age 65, will receive the benefits of this Certificate as primary unless such Subscriber elects Medicare as his or her primary coverage. However, the Subscriber must notify Us of the election by signing and submitting to Us and election card which indicates his or her choice. He or she must also pay any required premium. Any Subscriber who elects Medicare as primary shall not be eligible for coverage under this Certificate as of the date of election.

2. If your Group has 100 or more employees or your group is an organization which includes an employer with 100 or more employees, any active employee, spouse of an active employee or Dependent child of an active employee who becomes or remains a member of the Group Covered under this Certificate, after becoming eligible for Medicare due to disability, will receive the benefits of this Certificate as primary unless the Subscriber elects Medicare as his or her primary coverage. However, the Subscriber must notify Us of his or her election by signing an election card which indicates his or her choice. He or she must also pay any required premium. Any Subscriber who elects Medicare as primary will not be eligible for coverage under this Certificate as of the date of this election.

3. Any Subscribers who are not subject to subsections 1 and 2 of this Section and who are Medicare eligible must be enrolled in both Part A and Part B of Medicare to be eligible for benefits under this Certificate. FAILURE TO MAINTAIN MEDICARE BENEFITS UNDER PART A AND B WILL RESULT IN IMMEDIATE TERMINATION OF THIS COVERAGE. Subscribers with Part A and B of Medicare will receive the benefits of this Certificate reduced by any benefits available under Medicare Part A and B.This applies even if the Subscriber fails to claim the benefits available under Medicare.

Section XIV.
General Provisions

1. Entire Agreement. This Certificate, Summary of Benefits, any Certificate riders issued by the Us and accepted by the Group, the Group Enrollment Agreement, and the individual applications of you and your Covered Dependents, if any, constitute the entire contract between the parties, and as of the effective date, supersede all other agreements between the parties. Any and all statements made to Us by the Group and any Subscriber or Covered Dependent will, in the absence of fraud, be deemed representations and not warranties, and no such statement, unless it is contained in a written application for coverage under this Certificate, shall be used in defense to a claim under this Certificate.

2. Form or Content of Certificate. No agent or employee of Us is authorized to change the form or content of this Certificate. Such changes can be made only through an endorsement authorized and signed by one of Our officers.

3. Identification Cards. The cards We issue to Members pursuant to this Certificate are for identification only. Possession of an identification card confers no right to Covered Services or other benefits under this Certificate. To be entitled to such services or benefits the holder of the card must, in fact, be a Member on whose behalf all applicable Premiums under this Certificate have actually been paid. Any person receiving services or other benefits to which he is not then entitled pursuant to the provision of this Certificate will be liable for the actual cost of such services or benefits.

4. Notice. Any notice required under this Certificate may be given to Us by U.S. Mail, first class, postage prepaid to the Member Services address listed in the front of the Certificate. Notice to a Member will be sent to the last address We have for that Member. Member agrees to provide Us with notice, within 31 days, of any change of address.

5. Interpretation of Certificate. The laws of the State of New York shall be applied to interpretations of this Certificate.

OXFORD HEALTH PLANS

Oxford Health Insurance, Inc.

Mental Health and Substance Abuse Rider

Your Certificate of Coverage & Member Handbook ("Certificate") is revised as follows:

I. Out-of-Network Coverage

Mental Health Services

Outpatient

We cover outpatient visits for the treatment of mental or nervous disorders. A "visit" for the purposes of this provision is 45 to 60 minutes of therapy.

Outpatient mental health services are Covered only when obtained from duly licensed: psychiatrists or practicing psychologists; or by certified social workers or mental hygiene facilities. Alcoholism and substance abuse related rehabilitation are not considered mental health services under this provision.

We Cover up to the amount of visits shown in your Summary of Benefits.

II. Precertification

All treatment received under this Rider must be precertified and described in Section I. Of your Certificate.

III. Coinsurance and Benefit Limitations

All covered Services under this Rider are subject to UCR, Deductible and the Coinsurance shown in your Summary of Benefits.

IV. Miscellaneous Provisions

All benefits are on a per Member, per calendar year basis.

The "Exclusions and Limitations," section of your Certificate is amended as follows:

a) The exclusion regarding inpatient alcohol and substance abuse treatment and detoxification is removed from the Certificate.

b) The exclusion regarding mental health services is removed from the Certificate.

This Rider supersedes any amendment or rider providing coverage for Mental Health and Substance Abuse previously issued by Us. In the event of a conflict between the provisions of this Rider and the Certificate, the provisions of this Rider will prevail. All other terms and conditions of the Certificate remain in full force and effect.

Nothing contained in this Rider will be held to vary, alter, waive, or extend any of the terms, conditions, provisions or limitations of the Agreement to which this Rider is attached, other than as specifically stated herein.

Oxford Health Insurance, Inc.

Mental Health and Substance Abuse Rider

Your Certificate of Coverage & Member Handbook ("Certificate") is revised as follows:

I. In-Network Coverage

1. Mental Health Services

a. Inpatient

We Cover Inpatient and Equivalent Care for the treatment of mental or nervous disorders. We define "Inpatient Care" to mean treatment provided in a hospital as defined below. "Equivalent Care" is provided in a setting, other than such hospital, that We and the Provider deem to be safe and medically appropriate.

We reserve the right to provide this benefit in the modality We determine to be both medically appropriate and the most cost effective.

Inpatient and Equivalent Care mental health services are Covered only when obtained from facilities licensed by the appropriate state regulatory authority as well as any other Provider We deem appropriate to provide the Medically Necessary level of care. Alcoholism and substance abuse related rehabilitation are not considered mental health services under this provision.

For Inpatient and Equivalent care, We cover up to the amount of days shown in your Summary of Benefits.

b. Outpatient

We cover outpatient visits for the treatment of mental or nervous disorders. A "visit" for the purposes of this provision is 45 to 60 minutes of therapy.

Outpatient mental health services are Covered only when obtained from duly licensed: psychiatrists or practicing psychologists; or by certified social workers or mental hygiene facilities. Alcoholism and substance abuse related rehabilitation are not considered mental health services under this provision.

We Cover up to the amount of visits shown in your Summary of Benefits.

Alcoholism and Substance Abuse

a. Detoxification

Inpatient detoxification is Covered up to the amount of days and admissions shown in your Summary of Benefits.

b. Inpatient Services

Treatment in a Plan Specialized Rehabilitation Facility will be Covered, in accordance with an individual treatment plan prepared by your Provider. Coverage is limited to the amount of days shown in your Summary of Benefits.

II. Precertification

All treatment received under this Rider must be precertified and described in Section I. Of your Certificate.

III. Coinsurance and Benefit Limitations

All covered Services under this Rider are subject to UCR, Deductible and the Coinsurance shown in your Summary of Benefits.

IV. Miscellaneous Provisions

All benefits are on a per Member, per calendar year basis.

The "Exclusions and Limitations," section of your Certificate is amended as follows:

a) The exclusion regarding inpatient alcohol and substance abuse treatment and detoxification is removed from the Certificate.
b) The exclusion regarding mental health services is removed from the Certificate.

This Rider supersedes any amendment or rider providing coverage for Mental Health and Substance Abuse previously issued by Us. In the event of a conflict between the provisions of this Rider and the Certificate, the provisions of this Rider will prevail. All other terms and conditions of the Certificate remain in full force and effect.

Nothing contained in this Rider will be held to vary, alter, waive, or extend any of the terms, conditions, provisions or limitations of the Agreement to which this Rider is attached, other than as specifically stated herein.

Exhibit M

Pursuant to Rule 5 of the United States District Court for the Southern District of New York Procedures For Electronic Case Filing only excerpts of the referenced document have been electronically filed due to the volume of the exhibit.

(This exhibit has been Bates Stamped and a complete copy is being served on plaintiff.).

This filing is without prejudice to any parties' right to supplement the exhibit or file the complete document.

EC1227_CSP02

REDACTED
NEW YORK, NY 10028

Your Oxford Coverage for all seasons

OXFORD HEALTH PLANS®
A UnitedHealthcare Company

EC1227_CSP02

REDACTED
NEW YORK, NY 10028

FREEDOM PLAN CLASSIC

OXFORD
HEALTH PLANS®
A UnitedHealthcare Company

18 Feb 2008
5427 (07/05)

OXFORD
HEALTH PLANS®
A UnitedHealthcare Company

Dear Oxford Member,

Welcome, and thank you for selecting Oxford Health Plans.

At Oxford, your satisfaction is important to us, and we strive to help make your healthcare experience a positive one. As an Oxford Member, you have access to a series of programs and resources to help you along your road to health:

- A robust network of hospitals and providers from a local health plan with over 20 years of experience. If your employer's plan offers out-of-area coverage, you also have in-network national access outside of Oxford's tri-state service area through the UnitedHealthcare Choice Plus network.
- Our *Healthy Bonus*®[1] program, which consists of special offers and discounts that help you stay healthy and manage special conditions. Members can save on services such as weight loss programs, fitness equipment and publications.
- Our web site, *www.oxfordhealth.com*, which allows you to conduct business (e.g., request an ID card, update or correct any personal information, etc.) and access health information at your convenience.
- Healthcare guidance 24 hours a day, seven days a week, from Oxford's registered nurses through *Oxford On-Call*®
- *Healthy Mind Healthy Body*® magazine, your source for health information on prevention, nutrition, and exercise, as well as important benefit and coverage information.

The following information is enclosed: your new Summary of Benefits, Certificate of Coverage and other important plan information. If you have questions about your coverage, or want to learn more about Oxford's programs and resources, please log on to *www.oxfordhealth.com* or call Customer Service at the number on your Oxford ID card.

Wishing you the best of health,

Oxford Health Plans

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[1] *Healthy Bonus* offers are not insured benefits and are in addition to, and separate from, your benefit coverage through Oxford Health Plans. These arrangements have been made for the benefit of Members, and do not represent an endorsement or guarantee on the part of Oxford. Offers may change from time to time and without notice and are applicable to the items referenced only. Offers are subject to the terms and conditions imposed by the vendor. Oxford Health Plans cannot assume any responsibility for the products or services provided by vendors or the failure of vendors referenced to make available discounts negotiated with Oxford; however, any failure to receive offers should be reported to Oxford Customer Service by calling the number on your Member ID card.

Services You May Need	In-Network Out-of-Pocket Expense	Out-of-Network Out-of-Pocket Expense
Physician Office and Home Visits		
Preventive Care Preventive Care for adults received Out-of-Network is limited to $300. Preventive Care for children received Out-of-Network is limited to $300.	Adults –No Charge Children – No Charge	Adults –Deductible and 20% Coinsurance Children – Deductible and 20% Coinsurance
Primary Care for Treatment of Illness or Injury	$10 copayment per visit	Adults –Deductible and 20% Coinsurance Children – Deductible and 20% Coinsurance
Physician Hospital Visits	No Charge	Deductible and 20% Coinsurance
Well-Woman Exams This benefit includes two well-woman examinations, age appropriate screening mammograms and two Pap tests.	No Charge **Please Note:** Preventive Screening Mammograms performed in accordance with the well-woman schedule in your Certificate are Covered at No Charge. All other mammograms will be Covered subject to No Charge.	Deductible and 20% Coinsurance
Diabetes Education & Self-Management	$10 copayment per visit	Deductible and 20% Coinsurance
Diabetes Supplies and Medications	$10 copayment per 31-day supply of each item.	Deductible and 20% Coinsurance
Pediatric Preventive Dental Coverage is provided through age 11 for one visit per Calendar Year.	No Charge	No Charge

Specialist Care Covered Services	In-Network Out-of-Pocket Expense	Out-of-Network Out-of-Pocket Expense
Physician (Specialist) Office and Home Visits	$15 copayment per visit	Deductible and 20% Coinsurance
Allergy Testing & Treatment	$15 copayment per visit	Deductible and 20% Coinsurance
Chiropractic Services	$15 copayment per visit	Deductible and 20% Coinsurance
Obstetrical Services Coverage includes prenatal and postnatal care.	$10 copayment per initial visit Inpatient hospital services are Covered subject to: the inpatient facility Out-of-Pocket Expense.	Deductible and 20% Coinsurance

Please Note: Unless otherwise indicated, all benefit maximums and limitations are applied on a per Member, per Calendar Year basis and apply to both In-network and Out-of-Network Covered Services combined.

Specified Covered Services	In-Network Out-of-Pocket Expense	Out-of-Network Out-of-Pocket Expense
Laboratory Procedures and X-ray Examinations	No Charge	Deductible and 20% Coinsurance
Diagnostic Mammography	No Charge	Deductible and 20% Coinsurance
Radiology Services (Facility Based)	No Charge	Deductible and 20% Coinsurance
Durable Medical Equipment Coverage is limited to a maximum payment by Us of $1,500.	No Charge	Deductible and 20% Coinsurance
Medical Supplies	No In-Network Benefit	Deductible and 20% Coinsurance
Prosthetic Devices (External)	No Charge	Deductible and 20% Coinsurance
Prosthetic Devices (Internal)	No Charge. Surgery is subject to either the inpatient or outpatient facility Out-of-Pocket Expense.	No Charge Surgery is subject to Deductible and 20% Coinsurance
Second Opinions	At your request – $15 copayment per visit At Our request – No Charge	Deductible and 20% Coinsurance
Transplants	When performed at Our approved facilities – No Charge When performed at other Network facilities – the services will be Covered on an Out-of-Network basis.	Deductible and 20% Coinsurance
Oral Surgery	All Specialist visits are subject to the Specialist Office Visit Out-of-Pocket Expense. All outpatient and inpatient facility visits are subject to the appropriate facility Out-of-Pocket Expense.	Deductible and 20% Coinsurance
Short-Term Rehabilitative Services (Physical, Speech and and Occupational) Inpatient services are limited to one consecutive 60-day period per condition, per lifetime. Outpatient services are limited to 90 visits per condition, per lifetime.	All Specialist visits are subject to the Specialist Office Visit Out-of-Pocket Expense. All outpatient and inpatient facility visits are subject to the appropriate facility Out-of-Pocket Expense.	Deductible and 20% Coinsurance
Infertility Services (Basic & Comprehensive)	All Specialist visits are subject to the Specialist Office Visit Out-of-Pocket Expense. All outpatient and inpatient facility visits are subject to the appropriate facility Out-of-Pocket Expense.	Deductible and 20% Coinsurance

Please Note: Unless otherwise indicated, all benefit maximums and limitations are applied on a per Member, per Calendar Year basis and apply to both In-network and Out-of-Network Covered Services combined.

Specialty Care Services	In-Network Out-of-Pocket Expense	Out-of-Network Out-of-Pocket Expense
Infertility Services (Advanced) Advanced Infertility Services are Covered In-Network only and are limited to a maximum of $10,000 per Member, per lifetime.	All Specialist visits are subject to the Specialist Office Visit Out-of-Pocket Expense. All outpatient and inpatient facility visits are subject to the appropriate facility Out-of-Pocket Expense.	Not Covered
Elective Termination of Pregnancy We Cover one procedure. This benefit is limited to a maximum of $350 per procedure.	No Charge	Deductible and 20% Coinsurance
Home Health Care This benefit is unlimited.	$15 copayment per visit	20% Coinsurance. Not subject to Deductible.

Hospital & Facility Based Covered Services	In-Network Out-of-Pocket Expense	Out-of-Network Out-of-Pocket Expense
Inpatient Hospital Services	No Charge	Deductible and 20% Coinsurance
Outpatient Hospital & Ambulatory Surgical Center	No Charge	Deductible and 20% Coinsurance
Skilled Nursing Facility Services This benefit is limited to 30 days.	No Charge	Deductible and 20% Coinsurance
Outpatient Alcohol & Substance Abuse Rehabilitation This benefit is limited to 60 visits per Calendar Year. Up to 20 of the visits may be used by the Member's family.	No Charge	Deductible and 20% Coinsurance
Inpatient Mental Health Services This benefit is limited to 30 days. Members may choose to exchange one inpatient day for two visits of partial hospitalization. Please note, visits for biologically based services will count toward this limit.	No Charge	Deductible and 20% Coinsurance
Outpatient Mental Health Services and Partial Hospitalization The benefit for outpatient services is limited to 30 visits. Partial hospitalization visits will accrue to the inpatient limit. Please note, visits for biologically based services will count toward this limit.	Office Visits- $15 copayment per visit Outpatient Facility and Partial Hospitalization- $15 copayment per visit	Deductible and 20% Coinsurance
Biologically Based Mental Health Services & Services for Children with Serious Emotional Disorders	Office Visits- $15 copayment per visit Outpatient Facility and Partial Hospitalization- $15 copayment per visit Inpatient Facility-No Charge	Deductible and 20% Coinsurance

Please Note: Unless otherwise indicated, all benefit maximums and limitations are applied on a per Member, per Calendar Year basis and apply to both In-network and Out-of-Network Covered Services combined.

Hospital & Facility Benefit Covered Services	In-Network Out-of-Pocket Expense	Out-of-Network Out-of-Pocket Expense
Hospice Services This benefit is limited to 210 days (combined inpatient, outpatient and home hospice). 5 sessions of bereavement counseling are available for the Member's family either before or after the death of the member.	All Specialist visits are subject to the Specialist Office Visit Out-of-Pocket Expense. All outpatient and inpatient facility visits are subject to the appropriate facility Out-of-Pocket Expense.	Deductible and 20% Coinsurance
Home Hospice This benefit is limited to 210 days (combined inpatient, outpatient and home hospice).	$15 copayment per visit.	20% Coinsurance. Not subject to Deductible.

Medically Necessary Ambulance & Covered Services	In-Network Out-of-Pocket Expense	Out-of-Network Out-of-Pocket Expense
Ambulance Services	No Charge	No Charge
Emergency Room Services	$50 copayment per visit (waived if the Member becomes confined in a hospital).	When proper notice is given, Emergency Room Services will be Covered as an In-Network benefit. When proper notice is not given, Medical Emergency Admissions are Covered as described in the Certificate subject to Deductible and 50% Coinsurance.
Urgent Care Facility Services	When proper notice is given the services of In-Network and Out-of-Network Providers are Covered at: $15 copayment per visit	When proper notice is given, Urgent Care Facility Services will be Covered as an In-Network benefit. When proper notice is not given, Urgent Care Facility Services are Covered subject to Deductible and 20% Coinsurance.

Supplemental Services	In-Network Out-of-Pocket Expense	Out-of-Network Out-of-Pocket Expense
Exercise Facility Reimbursement	Within one 6-month period We will reimburse you $200. We will reimburse your spouse (or Domestic Partner if the Group has purchased this coverage) $100 per 6-month period. You must complete 50 visits within the 6-month period.	
Inpatient Alcohol & Substance Abuse Rehabilitation & Detoxification Services This benefit is limited per Calendar Year to 30 days for rehabilitation and 7 days for detoxification.	No Charge	Deductible and 50% Coinsurance
Prosthetic Repair and Replacement	No Charge	Deductible and 20% Coinsurance

Please Note: Unless otherwise indicated, all benefit maximums and limitations are applied on a per Member, per Calendar Year basis and apply to both In-network and Out-of-Network Covered Services combined.

Supplemental Coverage	In-Network Out-of-Pocket Payment	Out-of-Network Out-of-Pocket Payment

Outpatient Prescription Drugs

Please Note: Coverage for modified solid food products, as described in the Prescription Drug Rider, is limited to $2,500.

Retail Benefit	<u>Triple Tier</u> Tier 1 Drugs: $7 copayment Tier 2 Drugs: $20 copayment Tier 3 Drugs: $50 copayment Please Note: The above Copayments are applied to each 31-day supply of a Prescription Drug.	Not Covered
Mail Order Benefit	You will be responsible for 2 retail Copayments for each 90-day supply of Prescription Drugs.	Not Covered

Please Note: Unless otherwise indicated, all benefit maximums and limitations are applied on a per Member, per Calendar Year basis and apply to both In-network and Out-of-Network Covered Services combined.

[redacted]

Inpatient admissions for Obstetrical Services, Inpatient Admission for Elective Termination of Pregnancy, Inpatient admissions for Allergy Testing & Treatment, Inpatient Short-Term Rehabilitative Services, Orthoptic Exercises and Corneal Topographic Procedures, Oral Surgery, Laboratory Procedures, X-ray Examinations, and Facility-Based Radiology Services- including PET scans, MRA, MRI, Bone Density Studies, Nuclear Medicine, CAT Scans, Ultrasound and surgical endoscopic procedures, Infertility Services, Radiation/Chemotherapy, Prosthetic Devices, Durable Medical Equipment (Precertification required before purchase), Medical Supplies, Transplants, Home Health Care, Chiropractic Services, Inpatient Hospital Services, Outpatient Hospital Services and Ambulatory Surgical Center Services, Inpatient Hospice Services, Skilled Nursing Facility Services, Inpatient Alcohol Abuse Rehabilitation & Detoxification, Inpatient Substance Abuse Rehabilitation & Detoxification, Inpatient and Outpatient Facility Biologically-Based Mental Health Services, Inpatient and Outpatient Facility Non-Biologically-Based Mental Health Services, Urgent Care Facility Services.

Additional Plan Information Unless otherwise indicated, all benefit maximums and limitations apply to both In-Network and Out-of-Network Benefits combined.
Plan Deductible for In-Network Covered Services	Individual: There is no In-Network Deductible Family: There is no In-Network Deductible .
Plan Deductible for Out-of-Network Covered Services	Individual: $3,000 Family: $7,500
Out-of-Network Benefit Limit	The Out-of-Network benefits are unlimited.
Out-of-Pocket Maximum for In-Network Covered Services	Individual: There is no In-Network Out-of-Pocket Maximum. Family: There is no In-Network Out-of-Pocket Maximum. **Please Note:** Only Copayments, Deductibles, and Coinsurance paid for In-Network Covered Services contribute to your In-Network, Out-of-Pocket Maximum. Deductible and Coinsurance for Out-of-Network Covered Services, amounts in excess of the UCR, amounts paid for non-Covered Services, and any amounts paid as a penalty do not count toward the In-Network Out-of-Pocket Maximum. Coinsurance paid for any Covered Service obtained under Supplemental Coverage (excluding State mandated offers) will not be applied toward the In-Network Out-of-Pocket Maximum.
Out-of-Pocket Maximum for Out-of-Network Covered Services	Individual: $5,000 Family: $12,500 **Please Note:** Only Coinsurance and Deductibles paid for Out-of-Network Covered Services contribute to your Out-of-Network, Out-of-Pocket Maximum. Copayments for In-Network benefits, amounts in excess of the UCR, amounts paid for non-Covered Services, and any amounts paid as a penalty do not count toward the Out-of-Pocket Maximum. Coinsurance paid for any Covered Service obtained under Supplemental Coverage (excluding State mandated offers) will not be applied toward the Out-of-Network Out-of-Pocket Maximum.
Precertification Penalty	The list of services that require Precertification has been attached. If you fail to obtain a required Precertification for an Out-of-Network Benefit, you will be subject to a reduction in benefits. You must pay 50% of the costs for such service or supply.
UCR Reimbursement	The Group has selected UCR reimbursement for Out-of-Network benefits at 90th percentile of HIAA/Ingenix (when applicable). More information regarding Our UCR Policy and administration is available. You may request a copy of Our UCR Policy in the same manner as any Medical Policy. Please see your Member Handbook for information on how to obtain copies of Our Policies.

Please Note: Unless otherwise indicated, all benefit maximums and limitations are applied on a per Member, per Calendar Year basis and apply to both In-network and Out-of-Network Covered Services combined.

Eligibility Limits	The limiting ages for Dependents (as defined in the Certificate) are: • If not a full-time student: under the age of 19 • If a full-time student: between the ages of 19 and 23. Coverage ends at the end of the Calendar Year.
Effective Dates of Coverage	
Initial Enrollment (During initial Group Open Period)	Coverage is effective on the effective date of the Agreement.
Newly Eligible Employee (Application within 31 days of becoming eligible)	Coverage is effective on the effective date of the Agreement.
Newly Eligible Dependent(s) (Application within 31 days becoming eligible)	Coverage is effective as of the date the dependent became eligible. Coverage is effective at birth for newborns and newly born adopted children subject to the enrollment requirements as described in the Certificate.
Group Open Enrollment Period	Coverage is effective on the renewal date of the Agreement.

IMPORTANT: This document is not a contract. It is only a summary of your coverage. Please read your Certificate of Coverage and Member Handbook for a full description of your Covered Services, exclusions and other terms and conditions of coverage.

IMPORTANT: Coverage In-Network does not duplicate coverage Out-of-Network. **Benefits are not cumulative.** Benefits received In-Network reduce the amount of benefits available Out-of-Network. Benefits received Out-of-Network reduce the amount of benefits available In-Network.

Please Note: Unless otherwise indicated, all benefit maximums and limitations are applied on a per Member, per Calendar Year basis and apply to both In-network and Out-of-Network Covered Services combined.

A UnitedHealthcare Company

NY Large Classic Plan

Certificate of Coverage
&
Member Handbook

Cover Sheet

CERTIFICATE OF COVERAGE ("Certificate")
for
OXFORD HEALTH INSURANCE, INC. ("Oxford")

Please read this entire Certificate carefully, including your Summary of Benefits which contains information specific to your Group. These documents, and any attached riders, describe your rights and obligations and those of Oxford.

Under this Certificate, you engage Oxford to make arrangements through which medical and hospital services will be delivered in accordance with the terms and conditions of this Certificate and in reliance upon the statements you made in your application for coverage. Oxford agrees with the Group to provide the Covered Services set forth in this Certificate, as may be amended from time to time by Oxford or the Group's Board of Directors or similar body. Please note:

- This Certificate and any riders, schedules or attachments have been delivered in consideration of the Group's timely payment of Premiums.
- No services are Covered under this Certificate in the absence of current payment of Premiums, subject to a 30-day Grace Period and the terms and conditions of the Certificate.
- No services are Covered under this Certificate unless your coverage is in force at the time you receive services.
- In some instances a medical procedure may not be Covered or may require Precertification. It is your responsibility to understand the terms and conditions in this Certificate.
- This Certificate replaces any older Certificate issued to you which provided coverage under the Plan.
- This Certificate is not in lieu of and does not affect any requirements for coverage by Workers' Compensation Insurance.

This Certificate is governed by the laws of the State of New York.

Please Note: Unless otherwise expressly indicated in this Certificate, coverage will cease upon the termination of this Certificate. Benefit changes are effective on the renewal date of this Certificate. Benefits do not vest.

Section VI.
Exclusions and Limitations

(IMPORTANT: Neither the list of Covered Services nor the list of Exclusion and Limitations is exhaustive. Due to the ever changing availability of new medical technology, it is impossible to list every Covered Service or exclusion. If you cannot determine whether or not a specific services will be Covered, please call Us. Do not Assume that the service is Covered; there may be no coverage available.)

Unless coverage is specifically provided under this Certificate or provided under a rider or attachment to this Certificate, the following services and benefits are **not** Covered.

1. Services which We have determined are not Medically Necessary. If there is a dispute between a Provider and Us about the Medical Necessity of a service or supply, you or your Physician may appeal Our decision. Any disputed service or supply will not be Covered during the appeal process (please refer to the "Utilization Review Appeal" provision of this Certificate).

In no event will We seek reimbursement from a Member for the cost of any Covered Service provided under this Certificate that We determine is not Medically Necessary when such service was rendered by the Member's PCP or upon referral of the PCP

2. Fifty percent of the benefits normally payable for Covered Services for which a required Precertification was not obtained.

3. Unless added to this Certificate as described under "Supplemental Coverage," Acupuncture therapy.

4. Unless added to this Certificate as described under "Supplemental Coverage," Alcohol and Substance Abuse Services on an inpatient basis and detoxification are not Covered.

5. An adopted newly born infant's initial hospital stay if the natural parent has coverage available for the infant's care.

6. Birth control pills and implantable contraceptive drugs are excluded unless Supplemental Coverage for Outpatient Prescription Drugs (that includes these items) is purchased by the Group. Over-the-counter items such as condoms, foams or devices, contraceptive jellies and ointments are not Covered.

7. Care for conditions that by federal, state or local law must be treated in a public facility including, but not limited to, commitments for mental illness. Additionally, to the extent allowed by law, we do not Cover care or treatment provided in a Hospital that is owned or operated by any federal, state or other governmental entity.

8. Comfort or convenience items including, but not limited to: barber services; guest meals and accommodations; telephone, television or radio charges; travel expenses; or take-home supplies. We also do not Cover the purchase or rental of household fixtures or equipment including, but not limited to: escalators; elevators; swimming pools; exercise cycles; air purifiers; air conditioners; water purifiers; allergenic pillows, mattresses or waterbeds.

9. Cosmetic surgery, plastic or reconstructive surgery which is performed primarily to improve the appearance of any portion of the body including but not limited to: surgery for sagging of extra skin; any augmentation or reduction procedure (e.g., mammoplasty); liposuction; keloids; rhinoplasty and associated surgery. Complications of such surgeries are Covered only if they are Medically Necessary and are otherwise Covered. Remedial work is not Covered.

10. Court ordered services or services that have been ordered as a condition of probation or parole. However, these services may be Covered if We agree that the services are Medically Necessary, are otherwise Covered, the Member has not exhausted their benefit for the Calendar Year, and the treatment is provided in accordance with our policies and procedures.

11. Custodial care, domiciliary care, long-term care, maintenance care, adult day care or rest cures. We do not Cover room, board, nursing care or personal care which is rendered to assist a Member who, in Our opinion, has reached the maximum level of physical or mental function possible and will not make further significant clinical improvement.

12. Dental services related to the care, filling, removal or replacement of teeth and the treatment of injuries or diseases of the teeth, gums and temporomandibular joint, including, but not limited to: apicoectomy, orthodontics, root canals, soft tissue impaction, temporomandibular joint dysfunction therapy, alveolectomy, treatment of periodontal disease or orthognathic surgery. As described in Section IV, 2, F, "Oral Surgery," only dental services required to treat accidental injury of sound, natural teeth are Covered.

13. Diabetic services or supplies as follows. The following are not Covered as diabetic services or supplies: services or supplies that are not both Medically Necessary and prescribed by the Member's Physician or qualified health professional; membership in health clubs, diet clubs or plans for the purpose of losing weight even if recommended by the Member's Physician or qualified health professional; any counseling or courses in diabetes management other than as described as Covered under this Certificate; stays at special facilities or spas for the purpose of diabetes education or management; and special foods, diets aids and supplements related to dieting;

14. Durable Medical Equipment: We do not Cover: orthotics, arch supports, corrective shoes, false teeth, and hearing aids.

15. Experimental, investigational or ineffective; surgical or medical treatments, procedures, drugs, or research studies including, but not limited to: transplants, stem cell retrieval, cancer chemotherapy protocols, AIDS clinical trials or I.V. therapies that are not recognized as acceptable medical practice and any such services where federal or other governmental agency approval is

required but has not been granted. We will make the determination as to whether the requested service is excluded in accordance with this provision. In certain instances, such procedures may be Covered if they are approved in advance by one of Our Medical Directors and provided in accordance with the provisions of this Certificate.

Important: In general, We will not Cover experimental or investigational treatments. However, We shall Cover an experimental or investigational treatment approved by an External Appeal Agent certified by the State. If an External Appeal Agent approves coverage of an experimental or investigational treatment that is part of a clinical trial, We will only Cover the cost of services required to provide treatment to you according to the design of the trial. We shall not be responsible for the costs of investigational drugs or devices, the costs of non-health care services, the costs of managing research, or costs which would not be Covered under this Certificate for non-experimental or non-investigational treatments provided in such clinical trail.

We will Cover autologous bone marrow transplants combined with high dose chemotherapy when **medically appropriate,** for the treatment of: advanced neuroblastoma, second remission acute leukemia, relapsed Hodgkin's disease, relapsed non-Hodgkin's lymphoma, and metastatic breast cancer or any other diagnosis that Our Medical Advisory Board determines to be appropriate. We will make the determination of when such treatment is **medically appropriate.** Such treatment must be approved in advance by one of Our Medical Directors and provided in accordance with the provisions of this Certificate.

16. Improper use of an emergency room or emergency admissions. Routine care and treatment for conditions that We determine were not Medical Emergencies, when received in an emergency room, are not Covered. If you are not certain whether the services you received are Covered, please submit them to Us for review.

17. Infertility treatment and supplies when used either to treat infertility or any other condition not Covered under this Certificate (e.g., genetic selection). The following, but not limited to, services and supplies are not Covered: injectable infertility drugs such as Pergonal, Metrodin etc., cost for an ovum donor or donor sperm; embryo or ovum transfer procedures, artificial insemination, sperm storage costs, cryopreservation and storage of embryos, ovulation predictor kits, in vitro services, in vivo fertilization, and all costs for and relating to surrogate motherhood (maternity services are Covered for Members acting as surrogate mothers). We also do not Cover services to reverse voluntary sterilizations. Treatment of an underlying medical condition will not be denied (if the treatment is otherwise Covered under the Certificate) solely because the medical condition results in infertility.

18. Learning and behavioral disorders. Services for the evaluation or treatment (including remedial education) of: learning disabilities or minimal brain dysfunction; mental retardation; developmental and learning disorders or behavioral problems. We also do not Cover behavioral training or cognitive rehabilitation.

19. Unless added to this Certificate as described under "Supplemental Coverage," Mental Health Services are not Covered.

20. When Medicare is the primary payor, We Cover the Services provided by this Certificate only to the extent they are not Covered under Medicare. Please see Section XII, "General Administrative Policies and Procedures," subsection, "Medicare and Other Government Programs."22. Services and treatment provided in a government facility.

21. Services and treatment provided in a government facility.

22. No-fault automobile insurance. Any Covered Services that are payable as personal injury benefits under mandatory no-fault automobile insurance. Where permitted by state law, any Covered Services which are eligible for payment under the provisions of an automobile insurance contract or pursuant to any federal or state law which mandates indemnification for such services to persons suffering bodily injury from motor vehicle accidents.

23. Non-eligible institutions. Any services or supplies furnished by a non-eligible institution, which is defined as other than a Hospital or Skilled Nursing Facility, and which is primarily a place of rest, a place for the aged, or any similar institution, regardless of how denominated.

24. Non-medical services and long-term rehabilitation services for physical therapy or the treatment of alcoholism or drug abuse, including rehabilitation services in a specialized inpatient or residential facility, except as specifically Covered under this Certificate.

25. No-show charges. If a Provider charges a fee for a missed appointment, you will be responsible for the payment of the fee.

26. Occupational conditions, ailments, or injuries arising out of and in the course of employment. Such conditions, ailments or injuries are not Covered if they are subject to coverage, in whole or in part, under any workers' compensation, occupational disease or similar law. This applies even if the Member's rights have been waived or qualified.

27. Unless added to this Certificate as described under "Supplemental Coverage," Outpatient prescription drugs are not Covered. Over-the-counter medications, drugs and devices are also excluded.

28. Private or special duty nursing.

29. Rehabilitation services or physical therapy on a long-term basis. Speech or occupational therapy to correct a condition that is not the result of a disease, injury or a congenital defect for which surgery has been performed.

30. Routine foot care including nail trimming, corn and callous removal, cleaning, soaking or any other hygienic maintenance or care.

- Patient name
- Type of service
- Name and address of provider making the charge
- CPT-4 codes, or HCPCS codes (description of services)
- Date of service
- Individual charge for each service
- ICD-9 codes (diagnosis or symptoms)

Be sure to keep a copy of your claim form and bills for your own records.

Claim forms are available from the Group or from Us by calling the Member Services telephone number listed in the front of this Certificate. Completed forms should be sent to the address listed for "Claims" at the front of this Certificate.

2. Payment options

You may request Us to make payment directly to you or to the provider. If you want Us to pay the provider directly (referred to as assignment), you must give the provider a blank claim form to be completed and forwarded with the itemized bill.

If you decide to pay a provider directly, submit the completed claim form with your bill to Us for reimbursement as described above. Although We will generally follow your instructions, We reserve the right to make the final determination.

3. Limitations

All requests for reimbursement must be made within 90 days of the date Covered Services were rendered. Failure to request reimbursement within the required time will not invalidate or reduce any claim if it was not reasonably possible to provide such proof within the 90-day period. However, such request must be made as soon as reasonably possible thereafter.

All reimbursements to non-Network Providers are subject to UCR **unless** you were referred to a non-Network Provider by your PCP or Us.

4. If You Receive a Bill from a Network Provider

The cost of Covered Services provided by Network Providers in accordance with the terms of this Certificate will be billed directly to Us. **No claim forms are necessary.**

If you should receive a bill from a Network Provider for Covered Services, please contact the Member Service Department immediately.

5. Claim Information

Claims for Covered Services will be paid within 45 days after We receive proof of claim and all of the information we need to process the claim. If necessary, Our Claims Department will contact you for more information regarding your claim in order to speed up the processing. If you would like to inquire about the status of a claim, call the "Claims" telephone number list in the front of this Certificate. Please have the date of service and your ID number ready.

6. Physical Examination

We have the right and the opportunity to examine the Member who is the basis of any claim at all reasonable times while the claim is pending. This will be done at Our expense.

Section XI.
Other Important Documents

1. Supplemental Coverage by Rider

The terms and conditions of this Certificate are subject to revision, addition or deletion. Any such changes will be made by rider. The terms of a rider that is issued by Us and accepted by the Group will supersede conflicting terms in this Certificate. Riders that are part of your Plan will be issued with your Certificate. However, you may want to verify with the Group whether your Plan is subject to any rider.

Please check with your Benefits Administrator to make sure you have the most recent documents concerning your supplemental coverage under the Plan.

2. Summary of Benefits

In order to receive Covered Services under this Certificate, We may require that you pay a Copayment or Coinsurance to the Provider who supplied the Covered Services. In addition, certain other charges may be applied. You will receive a Summary of Benefits that will explain all of the applicable Copayments and Coinsurance as well as other similar features of your Plan. It will also list specific limitations on visits, days and dollar amounts for the benefits that are provided by the Plan.

Please check with your Benefits Administrator to make sure you have the most recent Summary of your coverage under the Plan.

3. Living Wills and Advance Directives

You have the right to participate in decisions relating to your health care. Working with your doctor, you can decide whether to accept or reject proposed medical treatments. That right extends to situations where, because of your medical condition, you are unable to communicate with your doctor or the hospital. This is done by the creation of an Advance Directive.

An Advance Directive is a written, signed document, that provides instructions for your care if you are unable to communicate your wishes directly. Depending on the state where you reside or are

If a Member enters into litigation or settlement negotiations regarding the obligations of other parties, the Member must not prejudice, in any way, Our subrogation rights under this section.

In the event that you suffer an injury or illness for which another party may be responsible, such as someone injuring you in an accident, and We pay benefits as a result of that injury or illness, We will be subrogated and succeed to the right of recovery against the party responsible for your illness or injury to the extent of the benefits We have paid. This means that We have the right independently of you to proceed against the party responsible for your injury or illness to recover the benefits We have paid.

The costs of Our legal representation in matters related to subrogation shall be borne solely by Us. The costs of legal representation of the Member shall be borne solely by the Member.

5. Worker's Compensation

Injuries and diseases covered under any Worker's Compensation program are excluded from coverage under this Plan.

6. Medicare and Other Government Programs

This Plan is not intended to duplicate any coverage for which Members are, or could be eligible for, such as Medicare or any other federal or state government programs. Any benefits payable under any such programs for Covered Services provided or benefits paid under this Certificate shall be payable to and retained by Us. You agree to complete and submit to Us any documentation reasonably necessary for Us to receive or assure reimbursement under Medicare or any other government programs for which you or your Covered Dependents are eligible.

Benefits for Medicare Eligibles Who are Covered Under this Certificate

1. If your Group has 20 or more employees, any active employee or spouse of an employee who becomes or remains a member of the Group Covered by this Certificate, after becoming eligible for Medicare due to reaching age 65, will receive the benefits of this Certificate as primary unless such Subscriber elects Medicare as his or her primary coverage. However, the Subscriber must notify Us of the election by signing and submitting to Us and election card which indicates his or her choice. He or she must also pay any required premium. Any Subscriber who elects Medicare as primary shall not be eligible for coverage under this Certificate as of the date of election.

2. If your Group has 100 or more employees or your group is an organization which includes an employer with 100 or more employees, any active employee, spouse of an active employee or Dependent child of an active employee who becomes or remains a member of the Group Covered under this Certificate, after becoming eligible for Medicare due to disability, will receive the benefits of this Certificate as primary unless the Subscriber elects Medicare as his or her primary coverage. However, the Subscriber must notify Us of his or her election by signing an election card which indicates his or her choice. He or she must also pay any required premium. Any Subscriber who elects Medicare as primary will not be eligible for coverage under this Certificate as of the date of this election.

3. Any Subscribers who are not subject to subsections 1 and 2 of this Section and who are Medicare eligible must be enrolled in both Part A and Part B of Medicare to be eligible for benefits under this Certificate. FAILURE TO MAINTAIN MEDICARE BENEFITS UNDER PART A AND B WILL RESULT IN IMMEDIATE TERMINATION OF THIS COVERAGE. Subscribers with Part A and B of Medicare will receive the benefits of this Certificate reduced by any benefits available under Medicare Part A and B.This applies even if the Subscriber fails to claim the benefits available under Medicare.

Section XIV.
General Provisions

1. Entire Agreement. This Certificate, Summary of Benefits, any Certificate riders issued by the Us and accepted by the Group, the Group Enrollment Agreement, and the individual applications of you and your Covered Dependents, if any, constitute the entire contract between the parties, and as of the effective date, supersede all other agreements between the parties. Any and all statements made to Us by the Group and any Subscriber or Covered Dependent will, in the absence of fraud, be deemed representations and not warranties, and no such statement, unless it is contained in a written application for coverage under this Certificate, shall be used in defense to a claim under this Certificate.

2. Form or Content of Certificate. No agent or employee of Us is authorized to change the form or content of this Certificate. Such changes can be made only through an endorsement authorized and signed by one of Our officers.

3. Identification Cards. The cards We issue to Members pursuant to this Certificate are for identification only. Possession of an identification card confers no right to Covered Services or other benefits under this Certificate. To be entitled to such services or benefits the holder of the card must, in fact, be a Member on whose behalf all applicable Premiums under this Certificate have actually been paid. Any person receiving services or other benefits to which he is not then entitled pursuant to the provision of this Certificate will be liable for the actual cost of such services or benefits.

4. Notice. Any notice required under this Certificate may be given to Us by U.S. Mail, first class, postage prepaid to the Member Services address listed in the front of the Certificate. Notice to a Member will be sent to the last address We have for that Member. Member agrees to provide Us with notice, within 31 days, of any change of address.

5. Interpretation of Certificate. The laws of the State of New York shall be applied to interpretations of this Certificate.

Oxford Health Insurance, Inc.

Mental Health and Substance Abuse Rider

Your Certificate of Coverage & Member Handbook ("Certificate") is revised as follows:

I. In-Network Coverage

1. Mental Health Services

a. Inpatient

We Cover Inpatient and Equivalent Care for the treatment of mental or nervous disorders. We define "Inpatient Care" to mean treatment provided in a hospital as defined below. "Equivalent Care" is provided in a setting, other than such hospital, that We and the Provider deem to be safe and medically appropriate.

We reserve the right to provide this benefit in the modality We determine to be both medically appropriate and the most cost effective.

Inpatient and Equivalent Care mental health services are Covered only when obtained from facilities licensed by the appropriate state regulatory authority as well as any other Provider We deem appropriate to provide the Medically Necessary level of care. Alcoholism and substance abuse related rehabilitation are not considered mental health services under this provision.

For Inpatient and Equivalent care, We cover up to the amount of days shown in your Summary of Benefits.

b. Outpatient

We cover outpatient visits for the treatment of mental or nervous disorders. A "visit" for the purposes of this provision is 45 to 60 minutes of therapy.

Outpatient mental health services are Covered only when obtained from duly licensed: psychiatrists or practicing psychologists; or by certified social workers or mental hygiene facilities. Alcoholism and substance abuse related rehabilitation are not considered mental health services under this provision.

We Cover up to the amount of visits shown in your Summary of Benefits.

Alcoholism and Substance Abuse

a. Detoxification

Inpatient detoxification is Covered up to the amount of days and admissions shown in your Summary of Benefits.

b. Inpatient Services

Treatment in a Plan Specialized Rehabilitation Facility will be Covered, in accordance with an individual treatment plan prepared by your Provider. Coverage is limited to the amount of days shown in your Summary of Benefits.

II. Precertification

All treatment received under this Rider must be precertified and described in Section I. Of your Certificate.

III. Coinsurance and Benefit Limitations

All covered Services under this Rider are subject to UCR, Deductible and the Coinsurance shown in your Summary of Benefits.

IV. Miscellaneous Provisions

All benefits are on a per Member, per calendar year basis.

The "Exclusions and Limitations," section of your Certificate is amended as follows:

a) The exclusion regarding inpatient alcohol and substance abuse treatment and detoxification is removed from the Certificate.
b) The exclusion regarding mental health services is removed from the Certificate.

This Rider supersedes any amendment or rider providing coverage for Mental Health and Substance Abuse previously issued by Us. In the event of a conflict between the provisions of this Rider and the Certificate, the provisions of this Rider will prevail. All other terms and conditions of the Certificate remain in full force and effect.

Nothing contained in this Rider will be held to vary, alter, waive, or extend any of the terms, conditions, provisions or limitations of the Agreement to which this Rider is attached, other than as specifically stated herein.

Oxford Health Insurance, Inc.

Mental Health and Substance Abuse Rider

Your Certificate of Coverage & Member Handbook ("Certificate") is revised as follows:

I. Out-of-Network Coverage

Mental Health Services

Outpatient

We cover outpatient visits for the treatment of mental or nervous disorders. A "visit" for the purposes of this provision is 45 to 60 minutes of therapy.

Outpatient mental health services are Covered only when obtained from duly licensed: psychiatrists or practicing psychologists; or by certified social workers or mental hygiene facilities. Alcoholism and substance abuse related rehabilitation are not considered mental health services under this provision.

We Cover up to the amount of visits shown in your Summary of Benefits.

II. Precertification

All treatment received under this Rider must be precertified and described in Section I. Of your Certificate.

III. Coinsurance and Benefit Limitations

All covered Services under this Rider are subject to UCR, Deductible and the Coinsurance shown in your Summary of Benefits.

IV. Miscellaneous Provisions

All benefits are on a per Member, per calendar year basis.

The "Exclusions and Limitations," section of your Certificate is amended as follows:

a) The exclusion regarding inpatient alcohol and substance abuse treatment and detoxification is removed from the Certificate.

b) The exclusion regarding mental health services is removed from the Certificate.

This Rider supersedes any amendment or rider providing coverage for Mental Health and Substance Abuse previously issued by Us. In the event of a conflict between the provisions of this Rider and the Certificate, the provisions of this Rider will prevail. All other terms and conditions of the Certificate remain in full force and effect.

Nothing contained in this Rider will be held to vary, alter, waive, or extend any of the terms, conditions, provisions or limitations of the Agreement to which this Rider is attached, other than as specifically stated herein.

2007 Benefit Update Rider

I. Covered Services

Section IV, Covered Services, Subsection 9, Mental Health Services has been added as follows:

9. Mental Health Services

We Cover diagnosis and treatment of mental, nervous or emotional disorders or ailments received on an outpatient or inpatient basis as described below. For purposes of this Certificate of Coverage "mental, nervous or emotional disorders or ailments" means Medically Necessary care rendered by an eligible practitioner or approved facility and which, in Our opinion, is directed predominantly at treatable behavioral manifestations of a condition that We determine:

- is a clinically significant behavioral or psychological syndrome, pattern, illness or disorder; and
- substantially or materially impairs a person's ability to function in one or more major life activities; and
- has been classified as a mental disorder in the current American Psychiatric Association Diagnostic and Statistical Manual of Mental Disorders.

A. Outpatient Mental Health Services

Precertification is required.

We Cover Mental Health Services received on an outpatient basis from duly licensed psychiatrists or practicing psychologists, certified social workers, or a facility issued an operating certificate by the commissioner of mental health, a facility operated by the office of mental health, a professional corporation or university faculty practice corporation including:

- Diagnosis.
- Treatment planning.
- Referral services.
- Medication management.
- Crisis intervention.

Coverage will be provided to the maximum number of visits shown on your Summary of Benefits. Please note, visits for biologically based services will count toward this limit.

B. Inpatient Mental Health Services

Precertification is required.

We Cover Mental Health Services received on an inpatient or partial hospitalization basis in a Hospital as defined by subdivision ten of section 1.03 of the mental hygiene law as well as any other Network Provider We deem appropriate to provide the Medically Necessary level of care.

If an Inpatient Stay is required, it is covered on a Semi-private Room basis. If partial hospitalization is precertified, two partial hospitalization visits may be substituted for one inpatient day. Coverage will be provided for active treatment to the maximum number of days shown on your Summary of Benefits. Please note, visits for biologically based services will count toward this limit.

Active treatment means treatment furnished in conjunction with inpatient confinement for mental nervous or emotional disorders or ailments that meet standards prescribed pursuant to the regulations of the commissioner of mental health.

Section IV, Covered Services, Subsection 10, Biologically Based Mental Illness has been added as follows:

10. Biologically Based Mental Illness

Precertification is required.

We Cover diagnosis and treatment of Biologically Based Mental Illnesses for adults and children received on an inpatient, partial hospitalization or outpatient basis. If partial hospitalization is precertified, two partial hospitalization visits may be substituted for one inpatient day. Coverage is also provided for children with serious emotional disturbances.

Biologically Based Mental Illnesses are defined as the following:

- schizophrenia/psychotic disorders,
- major depression,
- bipolar disorder,
- delusional disorders,
- panic disorder,
- obsessive compulsive disorder,
- bulimia and anorexia.

Children With Serious Emotional Disturbances are Members under the age of eighteen who have diagnoses of attention deficit disorders, disruptive behavior disorders, or pervasive development disorders, and where one or more of the following exists:

- serious suicidal symptoms or other life-threatening self-destructive behaviors;
- significant psychotic symptoms (hallucinations, delusion, bizarre behaviors);

- behavior caused by emotional disturbances that placed the child at risk of causing personal injury or significant property damage; or
- behavior caused by emotional disturbances that placed the child at substantial risk of removal from the household.

Section IV, Covered Services, Subsection 9, Supplemental Coverage, has been renumbered as Subsection 11. In addition, Paragraph B, Mental Health and Substance Abuse Services, Subparagraph 1, Mental Health Services has been deleted.

II. Exclusions and Limitations

Section V, Exclusions and Limitations, Item 20 is deleted and replaced with the following:

20. In addition to the exclusions identified in your Certificate of Coverage, the following are excluded from coverage under this rider:

- Services performed in connection with conditions not classified in the current edition of the *Diagnostic and Statistical Manual of the American Psychiatric Association.*
- Treatment provided in connection with services for individuals who are presently incarcerated, confined or committed to a local correctional facility or prison, or a custodial facility for youth operated by the office of children and family services, unless authorized by the Mental Health Designee.
- Services, solely because such services are ordered by a court.
- Services or supplies deemed cosmetic in nature. This also applies to services or supplies deemed cosmetic even if changing or improving an individual's appearance is justified by the individual's mental health needs.
- Any services for which the day or visit limit identified in the Summary of Benefits has been met. This exclusion does not apply to Biologically Based Mental Illness or Children With Serious Emotional Disturbances.
- Outpatient prescription drugs for the treatment of "mental, nervous or emotional disorders or ailments. Please Note: Coverage may be available for outpatient prescription drugs if the Group has purchased the Outpatient Prescription Drug Rider. Please check your Summary of Benefits to see if you have this coverage.

We may consult with professional clinical consultants, peer review committees or other appropriate sources for recommendations and information regarding whether a service or supply meets any of these criteria.

III. Copayments, Deductibles and Coinsurance

All office visits are subject to the Specialist Office Visit Copayment or Coinsurance listed in your Summary of Benefits. All outpatient facility visits are subject to the Copayment or Coinsurance required for Outpatient Hospital Services and Ambulatory Surgical Center Services listed in your Summary of Benefits. All inpatient procedures are subject to the Copayment or Coinsurance listed in the Summary of Benefits for Inpatient Hospital Services. All services are also subject to any applicable Plan Deductibles and UCR Reimbursement, as shown on your Summary of Benefits.

IV. Miscellaneous Provisions

This Rider forms a part of the Agreement between Oxford Health Insurance, Inc. ("Us") and the Group. Unless otherwise agreed to in writing between Us and the Group, this Rider becomes effective on the date the Agreement becomes effective.

This Rider supersedes any amendment or rider providing coverage described above previously issued by Us. In the event of a conflict between the provisions of this Rider and the Certificate, the provisions of this Rider will prevail. All other terms and conditions of the Certificate remain in full force and effect.